Maternal and Child Health Services
Title V Block Grant

State Narrative for Maine

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All appropriate Assurances, Non-construction Programs, and Certifications regarding debarment and suspension, drug free work place requirements, lobbying, program fraud civil remedies act, and environmental tobacco smoke are on file in the Maine Center for Disease Control and Prevention's, Division of Family Health and will be made available for review. Requests can be made through email to: Mary.Colson@maine.gov or by telephone at 207-287-9917.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

MCH programs elicit ongoing public input and consumer representation on committees and in activities. The Children with Special Health Needs (CSHN) and Youth Suicide Prevention Programs have successfully engaged youth in planning and advisory capacities resulting in youth oriented materials and activities specific to their needs. The CSHN Program actively involves parents on the advisory committee. Parents and consumers are recognized as critical components of successful programs and their input has been assured through their integration into routine program functions. Families of CSHN and youth are invited to review and comment on the application. Members of the CSHN family and youth advisory committee are invited to review and comment on the application.

The annual MCHBG planning and reporting processes, as well as, the annual application were discussed with the Joint Advisory Committee (Genetics and CSHN Programs), Newborn Hearing Advisory, School Health Advisory Committee, local WIC directors, medical providers, advocates and annual program and stakeholder meetings with requests made for public input. Consumer, provider, and family input is solicited at every opportunity at public forums such as committee and grantee meetings, conferences, and liaison groups. No public comments were received. The DFH will, during FY10, widely distribute emails to specific listservs sharing the Title V agency link and ask for comments on the MCHBG application.

A link to TVIS and the MCH Block Grant was added to the Division of Family Health (DFH) home page so visitors to the site can view the application http://www.maine.gov/dhhs/bohdcfh/FamilyHealth/family.html . For those who visit the Family Health website they can access the block grant which contains the Title V Director and CSHN Directors contact information.

The DFH will seek to collaborate with the Maine CDC's new Office of Local Public Health (OLPH) to identify ways to link to and engage local and district level stakeholder input related to maternal

and child health. The DFH leadership has discussed with the OLPH leadership how to include local public health districts in the upcoming 5-year comprehensive strengths and needs assessment. These discussions led to the Office of Local Public Health supporting our CSNA by inviting the DFH to include key MCH leaders in local Public Health Service Assessment meetings in each of the 8 PH District's across the state. These meetings are being held to conduct assessments to determine existing resource and service assets in relation to the 10 Essential Public Health Services, as well as, public health needs and gaps in each district.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

We were guided in the selection of the priority needs by the quantitative and qualitative analyses we completed. Quantitative data showed that mental disorders are an important issue affecting the MCH population in Maine. Qualitative data from the dialogue groups also identified mental health and the lack of available services, as well as family stress as key needs. As such, one of our new priority areas is to improve the mental health system of services and supports for the MCH population.

We developed our 10 priorities based on the data results, presented the priorities to Title V Program Managers, a wide array of stakeholders, and the public at large for their review and response, including all of the participants in the dialogues. From the responses, we finalized the priority list.

The priorities are broad in nature. This was intentional in that all people who work with and care about the MCH population have a stake in working together in a synergistic way on achieving these priorities. Furthermore, the wording of the priorities, expressed in terms such as improve, increase, and foster conditions, reflect our commitment to viewing MCH issues within a positive context and our vision for this document as a strengths and needs assessment.

The 2000-2005 priorities focused more on how we would achieve our work. The 2005-2010 priorities identify specific areas requiring health status improvement, but at the same time are broad enough to ensure inclusion of the whole MCH population in focused activities and in all aspects of a priority. We felt that too much specificity would jeopardize the obvious importance of many issues not making the list, and give the false impression that we favor addressing only certain segments and age groups of the MCH population. Our priorities, not expressed in rank order, are the following:

1. Improve birth outcomes
2. Improve the safety of the MCH population including the reduction of intentional and unintentional injuries
3. Improve the respiratory health of the MCH population
4. Increase the proportion of the MCH population who are at a healthy weight and physically active
5. Improve the mental health system of services and supports for the MCH population
6. Foster conditions to improve oral health services and supports for the MCH population
7. Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based system of care that enables whe whole CSHN population to achieve optimal health.
8. Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population.
9. Improve cultural and linguistic competence within the system of services for the MCH population
10. Integrate existing services and supports for adolescents and young adults into a comprehensive

system that draws upon their own strengths and needs.

The 2004-05 MCH Dialogues confirmed what we had hypothesized going into the Assessment: That we have made great strides in partnership building and collaboration during the past 5 years. We continue to develop new partnerships including: collaborating with Physicians for Social Responsibility and Maine Primary Care Association on a project to train health care providers on screening for domestic violence. Both organizations are actively involved in projects of the Safe Families Partnership, Maine Coalition to End Domestic Violence, Maine Coalition Against Sexual Assault and the Violence Intervention Project of Cumberland County; we are working with faculty and researchers at the University of Maine on domestic violence and rurality; Office of Minority Health is assisting with engaging members from minority communities such as the Maine Labor Council for Latin American Advancement; statewide Boys to Men Initiative is also actively engaged. /2009/ During FY08 the Divisions of Family Health and Chronic Disease collaborated with public health program (PH) evaluation faculty and staff from the University of Southern Maine and Maine Center for Public Health to design and implement a standardized PH evaluation framework. Through this framework the Divisions can realize efficiencies in funding the evaluation function for PH programs and progress to measuring longer-term program impacts and health outcomes. The Division of Family Health (DFH) is working with the new Office of Local Public Health (OLPH) to coordinate our 5-year CSNA with the PH district needs assessment (See Section IVA for more detailed description of Maine's emerging PH infrastructure and OLPH). DFH is also working with the Office of Child and Family Services, Children's Behavioral Health and the Community Caring Collaborative of Washington County to create a seamless system of care that is individually designed for each child and family through a wraparound process under the umbrella of Public Health. //2009//

Internal to the MCH Title V Program is our much-strengthened epi capacity through the addition of several new staff. We are now able to assign a liaison to each program within MCH permitting the Epi's to develop expertise about a program and its relevant data resources. This enhanced Epi capacity will have a positive long-term impact on our ability to collect, track, analyze, and apply accurate data to program planning and design. /2009/ We are also working with students and interns. We hosted a MCHB graduate intern during summer 2007 and a Colby College senior worked with the MCH Epi Team during January 2008 compiling MCH Block Grant data to be included in a Maine MCH Databook. The MCH Epi's also played a key role in the development of District Health Profiles which contain several MCH-related measures. The profiles were released to PH stakeholders around the state in Fall 2007. //2009// ***/2010/ Maine is hosting a MCHB graduate intern this summer. She will be involved with both the quantitative and qualitative data collection for our 5-year comprehensive strengths and needs assessment. //2010//***

In 2006 the DFH embarked on a strategic redirection process, looking in depth at how the available MCH human and financial resources are aligned with achieving the 10 MCH priorities developed in 2005. This process was completed in FY08.

/2009/ The new DFH structure consists of 5 sections; Community Collaboration, Integrated Systems, Operational Support, Public Health Nursing, and Special Needs (See Section III C Organizational Structure Division of Family Health organizational chart). The team leaders of these units comprise a senior management team which work with the Division Director in planning for programs within the division to ensure systems of care and service are in place to address needs of the MCH population. //2009// ***/2010/ The DFH structure was slightly modified to 4 sections; WIC, Public Health Nursing, Population Health and Prevention, and Special Needs. The Division is developing a Virtual Operations Section rather than a distinct stand-alone structure. //2010//***

III. State Overview

A. Overview

Geography

The demographic and geographic factors that account for Maine's uniqueness among the New England states are the very same factors that create complex challenges for the Maine Center for Disease Control and Prevention (Maine CDC) and Division of Family Health as they strive to improve health outcomes for the state's 1.3 million residents.

The other 5 New England states can fit into the 35,385 square miles occupied by the state of Maine. The population is distributed unevenly across the state; a third (35.8%) of Mainers live in the 2 southernmost counties (Cumberland and York), which together account for only 7% of the square miles in the state. Statewide we average only 41.3 people per square mile, as compared to 79.6 people per square mile in the United States as a whole. The population density varies dramatically across the state, from 317.9 people per square mile in Cumberland County, where Maine's largest city, Portland, is located, to 4.3 people per square mile in Piscataquis County. Statewide, 59.8% of the population lives in rural areas, as compared with 21.0% of the US population overall. In 5 Maine counties, 90% or more of the population lives in rural areas; 2 of these counties are 100% rural. Maine's large geographic area and widely dispersed population create challenges for accessing health care.

MCH populations (i.e., children, including those with special health needs and women of reproductive age) represent a significant proportion of Maine's population. ***/2010/ According to the 2008 US Census estimates children under age 18 make up 20.9% of Maine's population of 1.3 million. County estimates range from 19-22.6%. Nationally, in 2008 children under age 18 made up 24% of the total population. //2010//***

In 2000, 32.4% of Maine households included 1 or more children under 18 years, as compared with 36.0% of US households. (CSNA) 6.2% of Maine households consisted of a female householder with her own children under 18 years of age and no husband present. (CSNA) The comparable figure for the United States was 7.2%. (CSNA) ***/2010/ According to estimates from the 2005-2007 American Community Surveys (ACS) 30.4% Maine households included 1 or more children under age 18. Of the households with a child under age 18, 23.3% were female headed; 10.8% were male-headed households. In the US, 34% of households included a child under age 18. Of these 25.1% were female headed and 8.4% were male headed. //2010//***

Grandparents are the primary caregivers for a small proportion of children in Maine. The 2000 Census found that 1.7% of Maine adults aged 30 and over lived with grandchildren under 18 years of age. Similarly, 1.7% of Maine households included grandparents living with grandchildren. More than a third (38.9%) of the grandparents who lived with grandchildren were grandparent caregivers, defined as having primary responsibility for coresident grandchildren younger than 18. A third (28.1%) of grandparent caregivers were aged 60 and over. In half of the cases of grandparent caregivers, the child's parents were not in the household. One third (34.5%) of grandparent caregivers had been responsible for their grandchildren for 5 or more years. (CSNA) ***/2010/ According to the most recent data from the 2005-2007 ACS 1.7% of Maine adults over age 30 were living with their grandchildren, the same as in the 2000 Census. Of these 41.8% had primary responsibility for their own grandchildren under age 18. In the US 3.5% of adults over 30 were living with their grandchildren and 40.8% were responsible for caring for these children. //2010//***

The 2001 National Survey of Children with Special Health Care Needs (NS-CSHCN) found that 15.5% of Maine children aged birth to 17 years had special health care needs, (CSNA) defined broadly as those who have or are at increased risk for a chronic physical, developmental,

behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. 6 (CSNA) The corresponding proportion for the United States was 12.8%, which is significantly lower than that found in Maine. (CSNA) The proportion of children with special health needs in Maine increased with age, from 8.8% of 0-5 year olds to 16.2% of 6-11 year olds to 20.1% of 12-17 year olds. The US percentages for these age groups were 7.8%, 14.6%, and 15.8%, respectively. 23.5% of Maine households had 1 or more children under 18 years of age who had special health care needs, as compared with 20.0% of households in the U.S. (CSNA) ***/2010/ According to the most recent NS-CSHCN (2005-2006), 17.7% of Maine children age 0-17 have a special health care need. This is statistically significantly higher than the US proportion of 13.9%. //2010//***

Women of childbearing age, defined as 15-44 years, represented 21.0% of the Maine population in 2002, which was similar to the US figure of 21.7%. (CSNA) ***/2010/ As of July 1, 2008 women age 15-44 represented 19% of Maine's population and 37% of women in the state. //2010//***

Children under 18 years plus women of childbearing age together represented 40.5% of the Maine population in 2002. (CSNA) ***/2010/ According to 2008 US Census estimates 37.8% of Maine's population is made up of children under age 18 and women age 18-44. //2010//***

Maine has 16 counties of significantly varying sizes and population densities. Health care providers and infrastructure are distributed in direct relationship to population density. The largest, and one of the most sparsely populated counties, is Aroostook to the extreme north with 6,829 square miles, a population of 73,122 and only 73 primary care providers (physicians stating primary care as first specialty). These providers must serve a large, remote geographic area with essentially no major thoroughfares, limited resources, minimal support services, and hospitals designated as critical access only. In contrast, Cumberland County, one of the smaller and more densely populated counties to the south, has 1,217 square miles, a population of 269,083, three hundred eighty-seven primary care providers (physicians stating primary care as first specialty) and an extensive network of surface streets and roads.

Maine has three major cities: Portland population 64,249 (+1.8 % from 1990-2000); Bangor population 31,473 (-9.0%); and Lewiston population 35,690 (-10.3%). However, collectively the three largest cities account for only 10% of the state's residents. While 80% of American residents reside in metropolitan areas, the majority of Maine's residents continue to reside in rural towns and small cities that comprise the core of Maine's governmental structure.

Demographics

The 2000 Census provided a snapshot of the racial and cultural diversity of Maine's population. (Note: Census data are for the entire state population, not just the MCH population.) In 2000, Maine was 96.9% white, with little variation across counties. Statewide, 0.7% of Mainers were Asian, 0.6% were American Indian or Alaska Native, 0.5% were black or African-American, 1.0% were two or more races and 0.2% described themselves as being some other race. Less than 1% of the entire population was Hispanic; 1.2% of children under age 18 were Hispanic. A much larger proportion of the entire population is French-American; on the 2003 Behavior Risk Factor Surveillance System (BRFSS) survey, 19% of Maine adults ages 18 and over reported that they were French-American or Franco-American.

While Maine's population is predominantly white, the state is very gradually becoming more racially diverse. The proportion of the population that is white decreased from 98.4% on the 1990 Census to 96.9% on the 2000 Census. ***/2010/ Based on July 1, 2008 estimates 96.4% of Maine's population are White; 1% is Black or African American; 0.6% are American Indian; 0.9% are Asian; 0.04% were Native Hawaiian or Pacific Islander, and 1.1% were two or more races. Slightly more than 1% (1.3%) were Hispanic. //2010//*** Similarly, the proportion of Maine students in public and approved private schools who are white decreased from 97.5% in the 1993-1994 school year to 95.8% in the 2002-2003 school year. ***/2010/ In the 2006-2007***

academic year 94.6% of Maine public school students were White; 2.3% were Black or African American; 1.4% were Asian/Pacific Islander; 0.7% were American Indian; and 1.0% were Hispanic. //2010//

In the 2002-2003 school year, 77 languages other than English were spoken by school children in Maine. The nine most common languages spoken by Maine's Limited English Proficient (LEP) students in 2002 were French (spoken by 16.8% of LEP students), Spanish (12.9%), Passamaquoddy (10.7%), Somali (9.2%), Khmer (8.9%), Vietnamese (4.5%), Cantonese (4.0%), Russian (3.7%), American Sign Language (3.4%), and Serbo-Croatian (2.8%). (Note: The National Clearinghouse for English Language Acquisition & Language Instruction Educational Programs' Web site glossary states that LEP refers to students who have insufficient English to succeed in English-only classrooms.)

LEP students make up a small, but growing, proportion of Maine's school children. During the 2003-2004 school year, 1.6% of Maine students were LEP. This represented a 68.6% growth in LEP enrollment since the 1993-1994 school year; during this same time period, the total school enrollment in the state decreased by 10.9%.

Culturally and linguistically diverse (CLD) is another term used to describe diversity. The National Clearinghouse for English Language Acquisition and Language Instruction Educational Programs' Web site glossary states that the phrase refers to individuals from homes and communities where English is not the primary language of communication, although the individual may be bilingual or a monolingual English speaker. While statewide statistics are not available, in October 2003, 25.4% of Portland's public school students were CLD; the school-specific proportions ranged from 0.0% to 62.3%.

Statewide in 2000, 0.5% of Maine children 5-17 years old lived in linguistically isolated households, defined as households in which all members aged 14 years and older speak a non-English language and also speak English less than very well. The highest concentration (6.7%) of children in linguistically isolated households was found in the Madawaska primary care service area in Aroostook County.

Beginning around 2001, the number of people with Somali ancestry living in Maine began to steadily increase. People from Somalia who were assigned to Maine through the Refugee Resettlement Program found the size and safety of the communities in Maine and the values of Maine communities were compatible with the values of the communities they left behind in Somalia. Word spread through the network of Somali people in other parts of the United States resulting in an in-migration of people of Somali ancestry from other parts of the United States. Since 2001 approximately 3,000 Somalis have moved into Lewiston representing about 8% of the small city's population (2006 US Census estimate of 35,734). The same period saw over 1,600 Somalis moving to Portland. Initially Maine's largest cities of Portland and Lewiston were not prepared to provide services of the magnitude needed by refugee secondary migrants, Maine's newest residents. The initial year or so had some rough waters; however as the numbers of residents grew the capacity to provide more culturally appropriate services has grown and improved services continue to attract new arrivals at a rate of approximately 30 each month; most are settling in Lewiston. ***/2010/ While the number of Somalis and Sudanese moving to Maine from other U.S. communities has decreased, federal efforts to settle Iraqi refugees resulted in approximately 200 relocating to Portland. //2010//***

The availability of interpreter and translation services has increased since 2000, with the greatest growth in capacity in Portland and Lewiston, two of our largest cities. Public Health Nursing (PHN), a Title V program, uses a combination of individual translators and a language phone line. RISinterpret, a program of Catholic Charities Maine Refugee and Immigrant Services, has an ongoing contract with PHN to provide translation services. The other Title V programs rely primarily upon language phone line translators.

Current Socioeconomic Indicators

At the time of the 2000 Census, 79.2% of Maine women ages 22-44 were in the labor force; 3.9% of these women were unemployed. The corresponding figures for the United States were 73.4% and 5.4%. The proportion of women ages 22-44 who were in the labor force ranged from 72.7% to 81.9% across Maine counties. The county-specific proportion of women in the labor force who were unemployed ranged from 2.8% to 7.8%. (CSNA) ***/2010/ Maine, like the rest of the country has experienced a downturn in the economy. A large portion of Maine's economy is service related and when money tightens people tend to stop using services they feel can be delayed indefinitely, and reduced services have resulted in higher unemployment. With economic activity slowed, the Maine Department of Labor reported a preliminary seasonally adjusted May rate of 8.3% up from 5.1% for May 2008. Job gains were recorded in the areas of health care and social assistance. Job losses continued in manufacturing, construction, and financial activities. Other areas impacted during the past year have been leisure and hospitality services, government, and professional and business services.***

A January 2009, Families USA study of multiple years of US Census data revealed that as unemployment increases the number of uninsured rise. Maine was among 32 states where COBRA premiums for family coverage consume approximately three quarters of the average unemployment insurance income. Anecdotally we are hearing that many families are opting out of COBRA citing cost as a factor. Loss of jobs and insurance has also forced many people to delay or postpone medical care and stop or alter prescription medication dosages as a cost saving measure. //2010//

Maine women ages 18-64 with disabilities are less likely to be employed than are women in the same age range who do not have disabilities. The 2000 Census found that 44.6% of women with a sensory disability, 30.7% of women with physical disabilities, 28.4% of women with mental disabilities, 18.4% of women with self-care disabilities, 31.7% of women with go-outside-home disabilities, and 56.7% of women with employment disabilities were employed. The employment rates for Maine women ages 18-64 without each of these disabilities ranged from 72.3% to 75.2%. (CSNA) Maine has not yet met the Healthy People 2010 goal to eliminate disparities in employment rates between working-age people with and without disabilities.104 (CSNA)

Statewide in 1999, 16.2% of children under 5 years were below the federal poverty level, as were 12.9% of children 5-17, and 10.0% of individuals ages 18-64.(CSNA) The comparable percentages in 1989 were 15.7%, 13.1%, and 8.9%, respectively. (CSNA)
/2009/ A 2008 Maine Development Foundation report showed an increase in the poverty rate of Maine children 0-5 years from 13.9% in 2000 to 23.6% in 2006. The national rate was 19.3% and 20.7% respectively. //2009//

Looking at families in 1999, 16.0% of families with related children under 5 years of age were below the poverty level in Maine; the comparable figure for families with children under 18 years was 11.9%. A third (36.4%) of families with a female householder, no husband present, and related children under age 18 were below the poverty level; that figure rises to half (54.7%) of such families with children under age 5. (CSNA) ***/2010/ According to the 2005-2007 ACS 20.4% of families with children under age 5 in Maine lived below poverty. Of female headed households with children under age 18, 38.9% lived in poverty; more than half (59.4%) of female headed households with children under 5 lived in poverty. //2010//***

There is considerable variation in poverty and income measures across Maine counties. For example, the county-specific proportions of children under age 5 who are below the federal poverty level range from 10.5% to 25.2%.

The Maine Center for Economic Policy has calculated estimates of what Maine families need to earn to make ends meet in today's marketplace. This livable wage is based on a basic needs budget that takes into account actual living expenses, including housing, health care, child care,

transportation, and taxes. The livable wage is considerably higher than both the federal poverty level and the income of a minimum wage earner. The federal poverty level for a family of four in 2002 was $18,100. The annual income required for a 2-parent (2-earner) 2-child Maine family to meet a basic needs budget, in contrast, was $44,964, or 248% of the federal poverty level. (CSNA) As such, while significant portions of the MCH population are under the federal poverty level; even higher proportions are in families that do not earn livable wages. On March 31, 2006 Governor Baldacci signed into law L.D 1854, An Act to Expand the Alternative Aid Program. This bill increased the availability of alternative aid assistance in connection with the Temporary Assistance for Needy Families Program from a one time opportunity to once per calendar year in order to assist families who seek short-term assistance to obtain or retain employment or housing. The income eligibility limit for this program was increased to 133% of the poverty level. Another bill that directed the DHHS to annually report to the joint standing committee of the Legislature (Health and Human Services) having jurisdiction over health care matters on the Department's efforts toward meeting a goal of ensuring that at least 70% of eligible children had access to child care subsidies was voted out unanimous ought not to pass. /2009/ The WIC Program has seen a significant increase in the number of participants. Monthly enrollment has increased by almost 1,000. In addition there has been a sharp increase in the cost of WIC packages. //2009//

The Maine Development Foundation reported in 2004 that for the past 8 years only about 66% of jobs in Maine had paid a livable wage. (CSNA) In an effort to help the many Maine residents who struggle with one or more jobs to make ends meet, on April 13, 2006 Governor Baldacci signed into law L.D. 235 An Act to Increase the Minimum Wage. This bill increased the minimum wage from $6.50 to $6.75 October 1, 2006 and to $7.00 per hour effective October 1, 2007. While this rate is higher than the federal minimum it continues to lag behind other New England states (Vermont $7.25, Rhode Island $7.10 and Connecticut $7.40). /2009/ LD 1697 signed by Governor Baldacci on April 17, 2008 will increase Maine's minimum wage to $7.25 October 1, 2008 and $7.50 starting October 1, 2009. //2009//

Homelessness has increased significantly in Maine in recent years. It is estimated that in 2002 about 1,200 people were homeless in the state on any given night; 400-500 of these individuals were children. Over the course of a year, nearly 10,000 people spend time in homeless shelters; about 12% of these individuals meet the federal definition of chronic or long-term homelessness. In March 2002, people who were chronically homeless used as much as 70% of shelter resources in the state. Maine State Housing Authority (MSHA) data for July 2002 showed that 36% of people seeking shelter were female and 28% were under 18 years of age. Over half of shelter guests had substance abuse issues, but only 16% were currently receiving substance abuse services. A third (33%) of homeless individuals had serious mental illnesses; 40% had dual substance abuse and mental illness diagnoses.112 (CSNA)

/2010/ A Point in Time Survey conducted by the MSHA on January 30, 2008 revealed 776 people, including 139 children were homeless. Of the people identified as homeless, 685 agreed to complete the survey. 551 respondents were adults (18 years or older) and 120 were youth (under 18 years old). Of those for which gender data was collected, 34% were female, with the number of females peaking between the ages of 31 and 50. At the same time last year the number of females peaking was between the ages of 20 and 29. Five of Maine's homeless population reported being homeless for more than one year with 4% of these homeless for more than 2 years. In contrast, 63% reported being homeless for 6 months or less.

Factors most frequently cited as reasons for homelessness included: severe and persistent mental illness (31%), chronic substance abuse (29%), chronic disability (23%), and domestic violence (17%). In a January 2009 MSHA report on rural homelessness, providers noted anecdotally seeing an increase in teen parents and young families between the ages of about 16-24 who lack skills needed to live independently thus increasing the burden on shelters. //2010//

In 2002, housing resources for homeless people in Maine included 699 shelter beds for individuals, 356 shelter beds for families, 781 transitional housing units for individuals, 415 transitional housing units for families, 820 permanent supportive housing units for individuals, and 124 permanent supportive housing units for families. There are, however, gaps in program capacity. Shelters are sometimes completely filled and available beds are not always located within a reasonable distance of where homeless individuals are. As of 2002, 861 additional transitional housing units for individuals were needed, as were 994 transitional housing units for families, 621 permanent supportive housing units for individuals, and 640 permanent supportive housing units for families. (CSNA)

/2010/ Affordable housing continues to create challenges for many Maine residents. According to a 2008 MSHA Report on housing costs in Maine, the median price of homes increased 69% between 2000 and 2007 yet median income only increased 20% during the same period. The most affordable communities are in the more rural parts of the state (Aroostook, Piscataquis, and Somerset) with the least affordable in the southern and coastal areas. Similarly rents increased almost twice as fast as income, leaving only Aroostook county to be considered affordable to live. In addition, a slow economy with higher unemployment, high heat, gas costs and food prices are major issues facing Maine's most vulnerable. //2010//

Health Disparities

The majority of states have traditionally reported health disparities as health status differences between Blacks (African Americans) and Whites (Caucasians). In Maine our statistics don't show this ethnic disparity, probably because there is statistical insensitivity to the small numbers of Black residents in Maine. Maine's disparities are correlated with differences in education, income and low population densities of our rural areas. As part of Healthy Maine 2010 the Maine CDC looked at seven factors that may lead to health disparities in Maine: 1) race and ethnic background 2) sexual orientation (gay, lesbian, bisexual, transgender) 3) socioeconomic status (low income/less education) 4) disability 5) geography (urban versus rural) 6) gender and 7) age. The Maine CDC, in conjunction with the University of Southern Maine, Muskie School worked together to define the collection and reporting of data by race and ethnicity in response to federal OMB-15. The result of this work was to include the following racial categories on various Maine CDC forms: White, Black/African-American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and Other. Ethnic categories include Hispanic and given the state's large Franco-American population the workgroup recommended that the Maine CDC pilot Franco-American as an ethnicity option on forms and surveys. Pilots were conducted through the Maine Child Health fifth grade survey and the BRFSS. Analysis of the BRFSS pilot was conducted to determine potential relationships and correlations with health outcomes. Analysis revealed modest differences that seemed to be accounted for by differences in socioeconomic status and were most often not statistically significant.

Current Political Climate

During the 1995 to 2002 administration of Governor Angus King there was significant support for issues of concern for the MCH population. Activities including the formation of the Children's Cabinet, support for SCHIP, and dedication of State awarded tobacco settlement funds to public health to illustrate this commitment. As with any change in administration there was concern there would be a loss of support for MCH related issues. Fortunately this did not occur.

John Elias Baldacci, the first Democratic Governor in 16 years, was elected Governor in November 2002 and was re-elected in November 2006. The Democratic Party also won leadership of the Maine House and Senate. In the 2004 elections, the Democratic Party retained leadership of the Maine House and Senate. Maine's congressional delegation remains divided among the Republican and Democratic Parties. Olympia Snowe (R) and Susan Collins (R)

represent Maine in the Senate and Chellie Pingree (D) and Michael Michaud (D) in the House.

In 2002, during the gubernatorial election, now Governor John E. Baldacci promised to merge the Departments of Human Services and Behavioral and Developmental Services and to significantly change the structure and culture. Effective July 1, 2004 the new DHHS was mandated to improve services, increase efficiencies, and improve relations with community organizations. The improvement in services, efficiencies, and relations apply to all segments of DHHS from direct and purchased service sections to finance and operations sections. During FY05, the Department focused on determining the new organizational structure that would best achieve the statutory mandates listed above. The Legislature approved the plan submitted by Commissioner Nicholas. (See Organizational Structure Section III C) John R. Nicholas was confirmed Commissioner of DHHS in April 2004. Commissioner Nicholas retired in January 2006. Brenda Harvey, the acting commissioner of the former Department of Behavioral and Developmental Services was appointed acting commissioner of the DHHS. In April 2006, Governor Baldacci nominated Ms. Harvey to be the permanent head of the DHHS. She was confirmed on April 27, 2006.

Maine continues to be challenged economically particularly with our Native American population, some of Maine's poorest residents. Several referendum efforts put before the residents of Maine for improving the economic status of the Penobscot and Passamaquoddy tribes were defeated. Since November 2003 little progress has been made on potential economic sources of independence. In March of 2005 hope of a liquefied natural gas terminal on tribal land was lost when the local community voted against the terminal. The Houlton Band of Maliseet Indians announced in early 2006 their intent to build a bio-diesel processing plant on tribal land in southern Aroostook County. A feasibility study was completed but they were not able to secure financing. The Penobscot Nation opened a distribution center on Indian Island for mail-order prescription drugs (maintenance drugs for chronic conditions such as diabetes, high blood pressure and high cholesterol) in late 2005 but closed in early 2007 as a result of lower than anticipated sales. The tribes continue to seek business opportunities that will improve their economic status.

Impact of Welfare Reform on Women and Children

The advent of Title XXI, SCHIP in 1997 prompted changes in insurance coverage in Maine. Maine responded by expanding Medicaid and creating CubCare, a Medicaid-like Child Health Insurance Program (CHIP). This state operated insurance program for children, which includes EPSDT, was for ages birth through 18 years in families between 133% and 185% of the federal poverty level. In October 1999 the eligibility level was increased to 200% FPL. There is some cost-sharing for the CubCare Program. Outreach activities resulted in an increase in Medicaid enrollment to a current maximum of approximately 162,000. There are 27.5% (82,415) children ages 0-17 participating in Medicaid. Expansion of Medicaid and CubCare not withstanding, there are still serious concerns about the changing composition of our uninsured populations. In addition to the traditional numbers of uninsured working poor, there is a growing number of middle-income earners who cannot afford the escalating cost of premium co-pays required for dependent coverage. During the first session of the 120th Legislature, the name of the public insurance programs (i.e. Medicaid, CubCare, etc.) was changed to MaineCare. The name change went into effect in 2002.

Maine, like so many other states, continues to experience a decrease in state revenues resulting in a state budget shortfall. The most recent cuts have directly impacted service areas, particularly those purchased through the State Medicaid Agency. While enrollment and eligibility for MaineCare services have not been reduced, some services have been limited along with reductions in provider fees. /2009/ State and federal budget cuts have resulted in changes to MaineCare services that include reductions in children mental health services, foster care, occupational and physical therapy and rule changes that will restrict targeted case management services. Primary Care Case Management eligibility will be expanded to include members with

SSI income who are not eligible for Medicare, and participating physicians must oversee and manage care plans for patients with chronic conditions. //2009// ***/2010/ The 2010-2011 biennial budget requires many budget reduction initiatives within MaineCare. Details are not specific at this time but will be available after the start of SFY10 (7/01/09). We anticipate the MCH population will be impacted by the reductions. //2010//***

Statewide Health Care Delivery System (County & Local Health Departments)

Maine's rural nature and town meeting format of local government essentially preclude any significant County government structure or influence. The two largest cities maintain local health departments, however, there are no other health departments in Maine. Most public health functions are concentrated at the state level with minimal staffing and funding. The absence of local health departments and county government is further complicated by issues of uneven provider distribution, economic disparity, and a large rural population. All these challenges require the Maine CDC to provide some direct services in order to ensure statewide public health services access for our most vulnerable populations. The State's capacity to perform many categorical public health functions is extended through contracts with private health agencies; i.e. home health agencies; hospitals; rural health centers; and private physicians. Access is augmented by a developing telemedicine system statewide both in the areas of physical and mental health services. Hospitals and health centers particularly in the northern portion of the state are beginning to connect with specialists and tertiary care centers for consultation. Sunbeam Island Health Services (SIHS), a program of the Maine Sea Coast Mission offers health promotion and screening clinics via telemedicine to several of Maine's more remote islands. The Telemedicine program operates from the Sea Coast Mission ferry and is seen as an essential program to sustainable life on the isolated islands off the coast. Services vary from follow-up checks between prenatal visits to public health education. SIHS worked with the Ellsworth WIC office to become a WIC site and provides WIC services to Island women and infants. SIHS also met with and had a Case Manager, Occupational, and Speech Therapist from the Child Development Center in Ellsworth make a trip to one of the Islands to do pre-school screenings. The Program also arranges with providers around the state to deliver educational sessions via videoconference. Sessions included such topics as domestic violence and lyme disease.

Through Public Health Emergency Preparedness (PHEP) efforts and activities related to the Maine Turning Points Project, the Maine CDC and its' public health partners continue to focus on strengthening public health functions at the local level. Legislation to develop regional public health areas was withdrawn pending an assessment of its' fit with the Governor's proposed health plan. Establishment of regional epidemiology teams occurred through the state's PHEP activities, with the state divided into six (6) regions that align with the Emergency Medical Services regions. Renewed discussions around Maine's public health infrastructure began during FY06 when legislation was passed (L.D. 1614) to establish a system of Comprehensive Community Health Coalitions (CCHC). From this legislation a Public Health Workgroup (PHWG) was formed to design and make a recommendation on the framework for Maine's public health system. By January 1, 2007 the PHWG was to report to the Legislature on any action that it took with regard to core competencies, functions and performance standards for CCHCs and the resource inventory and integration of funding sources. The report was to include identification of administrative units and regions for the purposes of administration, funding and the effective and efficient delivery of public health services. Maine CDC Director, Dr. Dora Mills, is a member of the workgroup. The new agreed upon structure is described in Section IV A.

The Governor's Office of Health Policy and Finance led the development of Dirigo Health legislation passed at the end of the first session of the 121st Legislature. A major component of the legislation was the creation of a Health Insurance Program that included health promotion, disease management, quality initiatives and health coverage through private insurance carriers that individuals, self-employed, and small businesses could buy into. Anthem Blue Cross and Blue Shield won the award to provide the health benefit package for Dirigo Health. Enrollment in the Dirigo Health Insurance Plan started January 1, 2005. /2009/ Effective January 1, 2008

Harvard Pilgrim took over coverage for DirigoChoice subscribers. //2009// As of June 1, 2005 enrollment in Dirigo, including dependents was 7,311. Of those 2,925 were small business employees, 2,525 self-employed individuals, and 1,861 individuals who were unemployed or did not receive coverage through their employer. The Dirigo Health Agency reported 10,111 members enrolled as of May 31, 2006 an increase of 2,800 since June 30, 2005. More than 47% or 1,322 enrolled during January 2006. The higher January numbers were attributed to renewals or new plans that typically take place during January of each year. In addition Dirigo placed a cap on individual enrollment for the period June through December 2005 resulting in a flurry of activity when enrollment re-opened. Funding of the program continues to be controversial. A very contentious issue during 2006 was a Savings Offset Payment (SOP), a fee assessed on private insurers to support the program, determined by the savings resulting from Dirigo reforms in the state's health care system. Effective July 1, 2007 enrollment was temporarily suspended for individuals and September 1, 2007 for small businesses and self employed to allow the Dirigo Health Program to look for ways to cut costs after the legislature did not approve the Governor's request for additional funds to expand enrollments and on proposed changes in the program. Exceptions will be made for babies born to women who are already covered by Dirigo and new employees of small businesses with Dirigo contracts. /2009/ As of August 2007 Dirigo Choice was covering about 15,113 individuals (49%) and employees of small businesses (23%); the remaining 28% are sole proprietors. LD 2247 "An Act to Continue Maine's Leadership in Covering The Uninsured was signed by the Governor on April 16, 2008. In part this bill repealed the savings offset payment and replaced it with a health access surcharge on paid claims, broadened beer and wine taxes and imposed wholesale taxes on soda and syrup to fund the program providing for greater access to the uninsured. //2009// ***/2010/ A people's veto repealed this law in November 2008 leaving in place the savings offset as the funding mechanism. L.D. 1005 was passed on June 8, 2009 repealing the SOP and establishing a health access surcharge of 2.14% on all paid claims. As of September 2007, when new enrollment was suspended, 15,123 members were enrolled in Dirigo Choice; 28% were sole proprietors, 25% small groups, and 47% were individuals. No decision has been made on when enrollment will be reopened for those currently on waiting lists. //2010//***

In March 2006 Governor Baldacci proposed moving the Dirigo health plan out of Anthem Blue Cross/Blue Shield, the private insurer who had provided coverage during the prior year. He wanted Dirigo's Board to self-insure by creating a non-profit entity to run the insurance program. The Governor felt that self-insuring would eliminate the profit incentive allowing for the savings to pay for more coverage for Maine's uninsured. In May 2006 Governor Baldacci created a Blue Ribbon Commission to make recommendations for long-term funding and cost containment so that Dirigo Health could increase the affordability, accessibility, and quality of healthcare for Maine people. The report was issued in December 2006 and recommended funding the program from the State General Fund that could include taxes on specific behaviors and products that have a negative influence on health, for example tobacco products, snack tax, and a tax on bottled soft drinks to name a few. Regarding the cost containment, the Commission recommended a group be formed to carry out an independent review of the cost drivers in healthcare that effect both providers and payers. ***/2010/ The Advisory Council on Health Systems Development released its report in April 2009. The report concluded that high health care costs resulted from health care variation in inpatient and outpatient use of care, high outpatient hospital services, and high emergency department use. The full report that includes strategies to control cost growth can be found at: http://www.maine.gov/tools/whatsnew/attach.php?id=70889&an=1. //2010//***

/2009/ In April 2008 the 2008-2009 State Health Plan was released. The Maine CDC has been assigned responsibility for many of the activities that will focus on reducing Maine's healthcare costs driven primarily by utilization and inefficiency. Details of the plan can be found at: www.maine.gov/governor/baldacci/cabinet/health_policy.html. //2009//

Primary Care

Maine has two primary referral centers for health care needs: Maine Medical Center (MMC) in Portland and Eastern Maine Medical Center in Bangor. In addition there are 36 acute care hospitals (32 are birth hospitals with obstetrical services); 12 critical access hospitals; 17 Federally Qualified Health Centers (FQHC); 1 FQHC Look-a-like (St. Mary's in Lewiston) and 50 community health centers; 5 Indian Health Service funded health centers (3 on Reservations, 1 in Presque Isle, 1 in Houlton); and one osteopathic medical school. /2009/ In 2009 MMC will begin an affiliation with Tufts University School of Medicine in Boston (allopathic medical school). 20 of 36 seats will be reserved for Maine students. Three schools (University of Southern Maine, University of Maine at Orono and Husson College) offer Nurse Practitioner Programs. //2009// ***/2010/ Financial constraints forced 2 birthing hospitals to discontinue obstetric services in the past year; Parkview Hospital in the southern part of the state on February 28, 2009 and Blue Hill Memorial in the northern part of the state on May 30, 2009 reducing the number of birthing hospitals to 30. //2010//***

Prenatal Care

Efforts to improve maternal and infant status in Maine are complicated by our geography and population distribution. Multiple services are available locally prior to the occurrence of a normal pregnancy and continue through the postpartum period for women and through the first year for infants. However, our high-risk services are located in our three largest cities: Portland, Bangor, and Lewiston. Level III Facilities are located in Portland and Bangor. A Level II facility is located in Lewiston. Women without insurance or documentation can access service through a free-care pool of providers and monies. The Genetics Program manages a grant with Maine Medical Center for the provision of perinatal outreach, which includes education of providers and consumers regarding issues pertinent to pregnancy outcomes. Historically a greater proportion of Maine women (between 86 and 89%) receive prenatal care during the 1st trimester. Maine women receive routine clinical checks and pre-natal education. The Partnership for A Tobacco-free Maine is aggressively addressing smoking cessation among pregnant women and the 2000 PRAMS has added a smoking question to begin capturing data on this issue. There has been a decrease in the number of women who report drinking alcohol during pregnancy. In 1990 11% reported consuming alcohol while pregnant and in 2002, 5% reported drinking alcohol during the last 3 months of pregnancy. (PRAMS). We are hoping this is a reflection of increased education and awareness among patients, providers and staff who interface with pregnant women and new mothers. /2009/ A Perinatal Substance Abuse Workgroup was formed in October, 2003 by the MCH Medical Director to address the growing issue and number of babies exposed to prescribed narcotics and illicit drugs while in utero. Several educational conferences have been held for nurses, physicians, social workers and recovery treatment providers. Since the medical directors departure in January of 2008, Kelly Bowden, coordinator of the Perinatal Outreach Grant, is leading the group. A Future Search Conference is planned for winter 2009 on the topic of perinatal addiction. //2009// ***/2010/ The Workgroup was unsuccessful in securing funds for a Future Search Conference. Lacking leadership the Workgroup has been dissolved. Currently the Caring Community Collaborative in Washington County and the Portland Women's Task Force in Cumberland County focus on perinatal addiction. The Perinatal Nurse Manager maintains contact and provides consultation to both groups.//2010//***

High-Risk Care

A small portion of the states MCH funds support the 24-hour statewide availability of perinatology and neonatology consults for providers. Great care is taken to transport high-risk pregnant mothers to the appropriate facility prior to delivery. However, in the event this is not possible, or an infant is born with unexpected complications, both Level III facilities facilitate transport via provision of a specially trained and equipped neonatal transport team utilizing both air and ground transport. The Level II nursery in Lewiston has notified area hospitals that, with the departure of one of their neonatologists, it can no longer care for infants at less than 32 weeks gestation. Eastern Maine Medical Center, Level III Nursery in Bangor is gradually recovering from staffing

changes through recruitment of nurses and neonatal Nurse Practitioners. An experienced neonatologist joined the staff in 2005. The Central Maine Medical Center in Lewiston continues to limit its scope to pregnant women and neonates beyond 32 weeks gestation.

Birth Defects

Maine statute established the Birth Defects Program (BDP) in 1999. Legislation authorized the BDP to require reporting from Title 22, Hospitals and Title 32, Licensed Professionals; assure access to medical records, and allow contact with families to offer information and referral services. Rules for the BDP were promulgated in April 2003 and mandatory reporting began in May 2003. Through a collaborative partnership with the University of Maine's Center for Community Inclusion and Disabilities Studies the database system, ChildLINK, was developed to link public health data systems such as birth certificates, infant deaths, newborn hearing screening, newborn bloodspot screening and birth defects.

Abstraction of medical records for the BDP started in August 2003. Use of the ChildLink database and tracking system began implementation in March 2004 with the first hospital, Eastern Maine Medical Center in Bangor, beginning to report hearing screening results directly into the online database system. The BDP reports on the birth prevalence of 22 major birth defects. These birth defects fall into four major categories; central nervous system, chromosomal, musculoskeletal, and cardiac. During CY05 there were 45 confirmed cases and 57 for CY06. The coordinator continues the process of confirming the remaining cases. /2009/ During FY07 the BDP analyzed data from May 1, 2003 -- December 31, 2006. Of the 52,210 births 235 infants had a confirmed birth defect. With Maine's relatively low birth rate (approximately 14,000 per year) it may take several years of data gathering to determine the occurrence rates of selected birth defects. The BDP will use the data to provide information to the public and health care professionals about factors that may reduce or increase a woman's chance of having a baby born with a birth defect. //2009// ***/2010/ The BDP expanded the list of reportable birth defects to include upper and lower limb deformities and hypospadia. The BDP will begin an educational outreach program to birth hospitals in Summer 2009 to better inform providers of the requirements of the program, as well as, share information regarding birth defects in Maine. //2010//***

Pediatric Services

Pediatric services are provided by pediatric and family practice physicians as well as pediatric and family nurse practitioners and physician assistants. There are 963 Certified Nurse Practitioners in Maine but the Board of Nursing is unable to report on practice location. We estimate that 94% of our children now have insurance. Because of this, we phased out the PHN Well Child Clinics and are encouraging the connection of children to a pediatric medical home. Title V funds focus on specialty or wrap-around services (e.g. pre-delivery genetic testing and post-delivery genetic counseling, or the services of a pediatric specialist (e.g. pediatric endocrinologist). A recent challenge to health care services for all populations insured through MaineCare has been reimbursement for services provided. The Office of MaineCare Services (Medicaid) transitioned to a Client Management Information System beginning in January 2005. The new system is HIPAA compliant and requires more detailed billing information than the prior system. This resulted in the rejection of numerous claims from service providers. The problems are gradually being resolved though many service providers/agencies remain in a precarious financial situation until all issues are resolved. /2009/ Ongoing challenges with the system resulted in the decision to outsource to a fiscal agent, UNISYS, via contract. Transition planning is underway with projected implementation in July 2010. //2009//

CSHCN Services

/2010/ Financial constraints during FY06 resulted in the CSHN Program taking measures to reduce overall caseload. The CSHN Program no longer readily accepts those children served by MaineCare unless a particular service such as metabolic foods is not covered.

The CSHN further reduced its number by requiring parents to submit an IRS 1040 form that more accurately describes a family's income. Previously the program accepted self-declaration of income. This initiative further reduced the total number of children who receive direct service coordination. Currently the CSHN Program is serving 260 infants, youth and children with primary conditions of cleft lip and/or palate. The Department of Education (DOE), Division of Special Services reports that 34,425 (3-21) were served by special education. The DOE continues to experience a reduction in the overall number of students served by special education and reports school enrollment across Maine is declining. The DOE houses Child Development Services (Maine's Part C Program) and reported a total of 996 children ages 0 -- 2 were served. //2010//

In an effort to address issues faced by children and youth with special health needs and their families the CSHN is moving to a public health system of care. Utilizing State Implementation Grant for Integrated Community Services funds the CSHN Program has enhanced community development and systems integration by partnering with Maine Family Voices and the Maine Chapter of AAP to expand access to medical homes across the state. The Hood Center for Children and Families Initiative, Partners in Chronic Care was used to introduce and expand comprehensive care coordination services including transition to adulthood. The CSHN Program is focusing efforts on strengthening core program functions by establishing 6 regional Youth Advisory Committees and Family Advisory Committees. These 12 advisory committees submit an annual report card on the extent to which the six outcomes are being achieved. ***/2010/ A major programmatic change during FY08 was the implementation of a move from being a purchaser of medical services, serving a limited number of children and youth with special health care needs, to a program that assures a community-based system of care exists for all children and youth with special health care needs. The direct services team is developing a ranking system (described in PM # 4) for use as a guide in making decisions around service provision during the transition period from direct to population-based and infrastructure services. //2010//***

Maine's Access to Dental Care

/2010/ In 2009, 38 of Maine's 46 Dental Care Analysis Areas were designated as Dental Health Professional Shortage Areas (24 as population designations, including two Indian reservations, 14 as service area designations) along with the two state-administered mental health facilities in Augusta and Bangor. Four of these areas, Portland, Lewiston, Damariscotta, and Bangor no longer meet the federal requirements for designation and are being proposed for withdrawal. //2010//

Figures from the 2006 Maine Cooperative Health Workforce Resource Inventory indicate that the resident to dentist ratios in 11 of the 16 counties remain substandard to the national ratio of 1 dentist to 1700 residents. Fewer than half of Maine's practicing dentists treat MaineCare patients and relatively few will accept new MaineCare patients. Many dental practices in Maine continue at or close to capacity and many individuals, regardless of insurance or financial status, report difficulty in finding a dentist who is accepting new patients. Data from the 2008 survey is not yet available. In certain areas timely access to services continues to be of great concern. There are 23 private non-profit dental clinics in Maine (of which 12 are federally qualified health centers and one is an FQHC look-a-like), 3 State operated clinics that serve behavioral health clients, and 3 Indian Health Services dental clinics; there are also several preventive dental services programs and 3 programs that rely on volunteer dentists and referral networks.

Efforts to improve access to dental services in Maine have continued. The Oral Health Program (OHP) continued its support of the statewide Maine Dental Access Coalition, which functions as network and constituency for oral health. The Dental Services Development and Subsidy Program (DSDSP), authorized by the Legislature in 2001 to fund a capacity-building competitive grants program and a subsidy program for community-based dental clinics, continues to have strong support. ***/2010/ In FY09, 12 agencies providing services at 17 sites participated in the***

Subsidy Program //2010// Through the late 2003 round of DSDSP competitive grants, 10 agencies received funding; 8 grants were made for development and expansion and 2 for case management and community education. These grants included three budget periods, one through June 30, 2004 and the others for the succeeding state fiscal years, terminating on June 30, 2006. /2009/ These grants were continued through June 30, 2008, in anticipation of a planned RFP that was delayed pending decisions about funding allocations and consistency with other funding programs relative to Maine's new public health districts. ***/2010/ At this time (July 2009) available funds will be directed to the Dental Subsidy Program, and no "capacity-building" grants will be offered. //2010//*** The OHP, with support from a State Oral Health Collaborative Systems Grant from MCHB, published a state oral health improvement plan in 2007. ***/2010/With support from a 1-year workforce development grant from HRSA's Bureau of Health Professions, initial work in developing SMART objectives (Specific, Measurable, Achievable, Realistic, Time-framed) should be accomplished by the end of summer 2009. With the continuing support of a 5-year cooperative agreement from the US CDC's Division of Oral Health in its State-based Oral Disease Prevention Program, awarded in July 2008, the plan will be updated and refined, and reissued in 2010 or 2011. //2010//***

On September 14, 2007, Governor Baldacci signed an Executive Order establishing the Task Force on Expanding Access to Oral Health Care for Maine People. The Task Force is charged to develop recommendations for "short and long term solutions to expand access to high quality oral health care programs for all Maine residents," particularly children, the elderly, the underinsured and the uninsured, and to identify existing barriers to access and provide oral health care for Maine residents. The Task Force includes a representative from DHHS Office of MaineCare Services and staffing assistance is being provided by the OHP. The Task Force has been directed to (1) review relevant data and information on the status of oral health in Maine, as well as national studies on access to oral health care; (2) define a multi-year systems development approach to improving oral healthcare infrastructure, access to dental services and oral health status in Maine; and (3) consult with public and private individuals and organizations that provide medical and oral health care currently for the purpose of building upon existing relationships and partnerships. ***/2010/ The report was completed and submitted to the Governor and two legislative committees (Health and Human Services and Business, Research and Economic Development) on December 1, 2008. The Task Force reached consensus on 14 recommendations for expanding access to oral health care in Maine; some suggest legislative action, some require funding or financing, and others can be achieved by building on existing relationships and programs. They were organized into 6 categories: reimbursement, public safety and quality, workforce, finance, health and wellness promotion, and service expansion. The Task Force report and its recommendations formed the basis of or were cited in at least 13 legislative proposals in the 2009 legislative session. Several of these bills passed, making small changes in the Dental Practice Act for scope of practice issues for hygienists and denturists, but a proposal to increase MaineCare rates for 17 procedures (reduced in an amendment to 12) was tabled to the Second Session (January 2010) because of the projected expense to the state.***

The University of New England, a private institution with an emphasis on osteopathic medicine and health care workforce development, began a planning process in 2007 to determine the feasibility of a dental school for Maine and Northern New England. UNE's Board made a preliminary endorsement of the College of Dental Medicine on May 9, 2008. and approved the academic program in November 2008. /2010/ UNE has received a significant lead gift toward start-up costs and hopes to open the program to its first cohort of students in Fall of 2011. The College will use an emerging "distributive" model for dental education that will utilize existing clinical sites throughout Maine, with an emphasis on rural locations, and students will graduate with certificates of advanced studies in public health along with their dental degrees. //2010//

The University College of Bangor (UCB), a campus administered by the University of Maine Augusta, sponsors the only accredited program for certified dental assistants in Maine. In the fall

of 2008, UCB will launch its new Dental Assisting at a Distance program. The goal is to increase the pool of people who would be eligible to enroll in Expanded Function Dental Assistant (EFDA) training programs. EFDAs are seen as contributing to the productivity of dental practices and thereby to increasing access to services. //2009// ***/2010/ UCB expects to expand the Dental Assisting Program using distance learning technology starting in Fall 2009. York County Community College graduated its first class of 12 EFDAs at the end of 2008. Anecdotal reports indicate they are proving to be very effective. //2010//***

Mental Health Services

Traditionally the Office of System Integration had leadership responsibility for mental health in the state. The creation of the new DHHS in July 2004 opened up a myriad of possibilities for the Title V and Mental Health Agencies to unite in leadership to strengthen the systems and policies to support healthy emotional and cognitive development for all children and families. Mental health services (including substance abuse services) are divided into two populations, adult and children. These are being integrated with other services provided to those populations for a more effective and efficient delivery of services. New opportunities that have already emerged include:

1. The strong emphasis in the Humane Systems for Early Childhood Grant on social and emotional health. The
   Task Force on Early Childhood has an action team that specifically addresses how the state early childhood
   plan will recommend action steps to humanize and de-stigmatize our approach as a state to this issue.
2. Collaboration between Children's Behavioral Health Services (CBHS) and Title V on systems issues such as
   transition from youth to adulthood of people with special health needs and vulnerable groups such as high-
   risk youth who have fallen through the cracks.
3. Continued efforts, particularly through a Healthy Tomorrows Grant for a Behavioral and Developmental Clinic
   in York County and a Maine Health Access Foundation Grant to Kennebec Valley Mental Health, to integrate
   mental health into primary health care systems for the MCH population. /2009/ In April 2008, after
   negotiations between Southern Maine Medical Center and the Maine DHHS Commissioner Brenda Harvey, Dr.
   Donald Burgess succeeded in getting his pediatric office practice certified as a mental health provider; a first in
   the state. Dr. Burgess, the President of the Maine AAP Chapter, has been a champion in efforts to integrate
   mental health services into primary health care for children and youth. //2009// ***/2010/ Lack of reimbursement***
   for care management is threatening the integration of mental health services into primary health care in many
   pediatric offices. //2010//
4. Continued involvement of Title V leadership in a SAMHSA grant to strengthen state and local mental health
   systems as they relate to emergency preparedness.
5. Continued involvement of Title V leadership with efforts to strengthen systems of care for children affected by
   trauma. Such involvement included participation in a statewide conference in May 2005 on the relationship
   between adverse childhood experiences (ACE) and adult morbidity and mortality.
6. A new project, led by the Maine AAP and the Maine CDC, to raise awareness and change the role of

physicians in schools so that they become engaged as leaders in collaboration to address school health
issues that relate to social and emotional development.

The purpose of public health, as defined by the Institute of Medicine, is to foster conditions that will enable the whole population to achieve optimal health. At the center of public health is the human mind and spirit. The Maine Title V Program views the mental and spiritual health of children and families within the context of our five global priority areas as outlined in Section IV B of this application. We continue to sharpen and increase our focus on issues involving the mental health and primary health care systems.

Despite a significant growth in the number of licensed clinicians and psychiatrists in Maine, the need continues to outstrip demand. Primary care physicians are left picking up the slack, and they have to deal with a complex system with a history of less than optimal communication and collaboration. In recent years, CBHS embarked on a search to explore new and innovative means of addressing the challenges. The Maine Title V Program has been a partner in this search with child and adult mental health since 2003.

A promising model that we want to put into practice in Maine is an integrated system of primary care and mental health. While still relatively new, this system has been successfully implemented in other states. Although its details vary according to the unique needs and strengths of communities, the model views the primary care physician as the primary source of mental health care and focuses on developing a link between the child's medical home and their mental care system.

In 2001, at a meeting of the Public Health Committee of the Maine Medical Association, facilitated by Maine CDC Director Dr. Dora Mills, physicians identified mental health services as a pressing public health concern. In 2002, CBHS joined with the Maine Center for Public Health (MCPH) to continue this dialogue. In 2003, the MCPH, with strong support and involvement by the MCH Medical Director, received a planning grant from the Maine Health Access Foundation. The intent of the grant, conducted in partnership with CBHS, Maine Medicaid, and the Maine CDC, was to develop evidence-based integrated practice models that would be tested in a subsequent two-year applied research project. We hope that testing the models at a small number of sites will lead us to understand what works and what doesn't. The model can serve as a strategy for the state as a whole.

The planning grant ended in 2004. The Maine Health Access Foundation did not express interest in a follow-up system of care grant so the grant expired. CBHS took steps to further address this issue through action led by a newly hired Medical Director for Mental Health, Elsie Freeman, who expanded the reach of this effort to include services for people of all ages; and started work with MaineCare to alter its rules to facilitate integration. At this time, there are about 25 sites around the state that are using a variety of approaches to integration, and a number are studying outcomes. Also, the Department, including Title V, continues to strongly support integration and, in particular, Ed Wagner's Care Model out of Washington State. The Humane Early Childhood Systems Plan, released by the Children's Cabinet in March 2006, strongly emphasizes the need for strengthened integration of mental health and socio-emotional development into an early childhood system that provides essential resources, shares common standards for quality, and respects the diversity of Maine's children and families. CBHS, in partnership with Title V and many other agencies, is implementing its newly funded Trauma-Informed System of Care Grant. The emphasis of this grant on family and youth involvement, interagency collaboration, and cultural and linguistic competence mirrors the philosophy for humane systems change in Maine Title V. /2008/ A uniquely strong partnership between the Trauma-Informed System of Care Grant (Project THRIVE) and Title V has emerged. Since Title V, Project THRIVE, and the CBHSs of DHHS share a strong commitment to Future Search Principles (getting the whole system in the room, explore the whole context before acting on parts of it, focusing on common ground, and sharing management and responsibility), this new partnership is a natural fit. The MCH Medical

Director's leadership on cultural and linguistic competence parallels and complements the work of Project THRIVE. At the September 2006 Future Search Conference, "Coming Together to Create Family Centered Practice: A Future Search for Child and Family Systems in Maine", the Executive Director and Youth Coordinator at THRIVE played an instrumental role in assuring that youth involvement and cultural competence were two key common ground items that everyone agreed to. The Early Childhood Coordinator and the MCH Medical Director helped plan and facilitate this conference, and the ECC Coordinator has led the follow-up efforts which involve THRIVE. Further, both THRIVE and CBHS took part in the remarkable Maine AAP Open Forum on Adverse Child Experience Study and Resiliency held in November 2006. //2008//

The MCH Medical Director's leadership has helped to identify and recruit a group of Maine pediatric practices that are ripe for testing the models; made sure that the efforts of the State Early Childhood Comprehensive Systems Grant are connected with those of the project; advocated strongly for family and community involvement in all phases of the project; and joined in a panel on public policy at a statewide conference on mental health and primary health care in June 2004.

B. Agency Capacity

Our many partnerships and collaborations expand our capacity to ensure good penetration of services in all but the most northern area of our state and a few other remote pockets where we continue to be challenged by difficult access to care. The goal of both the Division of Family Health and the Division of Chronic Disease is to collaboratively promote health and prevent disease, injury and disability through a variety of cross programmatic public health interventions ranging from primary prevention through broad-based community health promotion initiatives, early detection, health systems interventions, delivery of health services and the promotion of healthy public policies. The vision is "that individuals, families and communities in Maine will achieve and sustain optimal health and quality of life" through:

1 Building systems and community capacities
2 Initiating and advocating for public health policy
3 Developing and delivering programs and services
4 Collaborating with others
5 Providing leadership

Maine Department of Health and Human Services, Division of Chronic Disease and Family Health (1997) and Family Health (1999), Vision Statement.

We are part of an ongoing national trend to re-evaluate the role of public health policy and programs in state systems and infrastructure. We use the five-year planning process as an opportunity to reassess our overall direction. Because we must continue to be the "safety net," and provide direct services for some of our most vulnerable residents, changes in program focus and activities must be done with great care and forethought. This is a multi-year process, requiring transitioning of resource allocations from traditional to current and emerging priorities. Continued collaboration with stakeholders and representative advisory groups is critical.

Strong relationships with organizations, in particular the Muskie School at the University of Southern Maine; University of Maine at Orono; Medical Care Development; and the Maine Center for Public Health are critical to our programs success. These organizations not only provide manpower but also make available critical expertise on issues important to Mainers. The Muskie School, specifically the Cutler Institute, Population Health and Health Policy representations, have also provided guidance and education regarding strategic planning and coalition building, skills essential to a healthy Title V program.

For several years the Division of Family Health has worked to increase our MCH epidemiology

capacity. The State Systems Development Initiative (SSDI) grant was restructured during fiscal year 2000 to provide partial support for the salary of a Masters prepared Epidemiologist specific to MCH. The SSDI funds were pooled with funds from the Childhood Lead Poisoning Prevention and Asthma Programs to hire a full-time Masters prepared Epidemiologist (Kathy Decker, MPH), who began in December 2000. During the summer of 2000, the Title V Director worked with Dr. Sonnenfeld, Chronic Disease Epidemiologist, in developing an application for a grant from the Council of State and Territorial Epidemiologists (CSTE) to support the hiring of a PhD prepared Epidemiologist for MCH. The application was approved and in the spring of 2002 Dr. David Ehrenkrantz, PhD in Public Health Administration, was hired as the MCH Epidemiologist. Dr. Ehrenkrantz resigned the position in April of 2004. In July 2004 a second Masters prepared epidemiologist was hired (Cindy Mervis, MPH), bringing the Epi Team to a total of 3 staff. A year long search resulted in the hire of Dr. Erika Lichter as the new PhD prepared MCH Epidemiologist, bringing the Epi Team to a total of 4 Epidemiologists as of June 2005. Also in 2004, the Title V Program was successful in obtaining an MCH Epidemiology Fellow, Meredith Anderson, MPH, for a two-year fellowship through the CDC and CSTE. In 2006 the Chronic Disease Division successfully obtained a Chronic Disease Epidemiology Fellow, Shannon DeVader for a 2-year fellowship through the CDC and CSTE. While her primary focus is chronic disease, she expressed an interest in MCH projects. In May 2007 Kathy Decker resigned her position. /2009/ Anthony Yartel, MPH was hired in November 2007 and Denise Yob, MPH came on board in May 2008. //2009// ***/2010/Farooq Ghouri joined the Epi Unit in February 2009, bringing the Epi Team to a total of 6 Epidemiologists. //2010//***

In the spring of 2005 the Childhood Lead Poisoning Prevention Program (CLPPP) organizationally moved from the Division of Family Health to the Environmental Health Unit (EHU). The EHU monitors and provides technical assistance in the area of adult lead poisoning. It was determined synergies would be gained by connecting CLPPP with EHU. The CLPPP Director attends the monthly Title V Program Manager meetings and meets quarterly with the MCH Medical Director and the Title V Director. To date this relationship has proven effective in maintaining collaboration and coordination of the CLPPP with the Title V Program. /2008/ Over time it has been difficult to maintain a close connection with the CLPPP. As the Family Health Division completes its' organizational restructure and evaluates how business is achieved we will look at ways to better integrate. //2008// /2009/ The leadership of the CLPPP was recently promoted to a local public health district liaison position resulting in a search for a new program director. In addition, the MCH Medical Director left his position resulting in no DFH representation on the CLPPP Advisory Committee. The Title V Director will work with the interim CLPPP Director to identify a new DFH representative for the CLPPP Advisory Committee. Recruitment for a new MCH Medical Director will begin in early FY09. //2009// ***/2010/ A successful search resulted in Dr. Stephen Meister joining the Division of Family Health as Medical Director. Dr. Meister represents the Family Health Division on the LEAd-ME Advisory Council (formerly CLPPP Advisory Council). During FY10 the Council will be reviewing and updating its' State Elimination Plan for Lead under the leadership of the new Program Director, Eric Frohmberg. //2010//*** Title V funded programs serving pregnant women, mothers, infants and children are detailed on the attached Table 1.

An attachment is included in this section.

C. Organizational Structure

The State Title V Agency in Maine is the Maine Department of Health and Human Services (DHHS). Administrative oversight of the Maternal and Child Health Services Block Grant is vested with DHHS's Center for Disease Control and Prevention (Maine CDC)

Programs, which focus primarily on the MCH population, are found in both the Division of Family Health (DFH) and the Division of Chronic Disease (DCD). The day-to-day management of the MCH Block Grant is carried out in the Division of Family Health, with Valerie Ricker designated as the manager with ultimate responsibility for administration of the MCH Block Grant. /2007/ A

recent partner, Maine's tobacco prevention program, known as the Partnership for a Tobacco-Free Maine (PTM), supports various MCH efforts through the Fund for a Healthy Maine (FHM). This fund was established in 1999 by the Legislature to receive and disburse tobacco settlement payments. Annually the largest proportion of FHM funds are directed toward tobacco prevention efforts. PTM routinely collaborates with the Teen and Young Adult Health, Women, Infant and Children, and Home Visiting Programs on tobacco-related issues. Other MCH related areas receiving FHM funds include providing support for childcare subsidies, school-based health centers, and family planning. PTM is located in the Maine CDC Division of Chronic Disease. //2007// The Childhood Lead Poisoning Prevention Program (CLPPP) organizationally relocated to the Environmental Health Unit (EHU). Over the years the CLPPP and EHU had increasing programmatic interests which led to a greater understanding of the synergies that could be achieved with augmented day to day integration of the programs.

September 17, 2005 phase 2 of the DHHS reorganization became law. Contained in the law were several components which impacted the Title V Program. First was a change in name of the Bureau of Health to the Maine Center for Disease Control and Prevention (Maine CDC). Second was the movement of the Early Childhood Initiative (ECI) and the Home Visitation Program (HV) to a new Early Childhood Division within the Office of Child and Family Services (OCFS), the state child welfare agency. The change in physical location, as well as, reporting configuration became effective January 2008. The ECI coordinator continues to meet with the Title V Director on the ECI and home visiting activities.

In May 2005 the Maine CDC started a 5-month strategic planning process based upon knowledge gained through The Strategy-Focused Organization by Robert S. Kaplan and David P. Norton. The strategic planning process resulted in relocation of several programs within the Maine CDC. The Maine Injury Prevention and Control and Teen and Young Adult Health Programs are now located within the Family Health Division. The Chronic Disease Division experienced a change in leadership in December 2005. Ron Bansmer, MBA, formerly the WIC Director, was promoted to the Chronic Disease Director. //2007// /2008/ Mr. Bansmer vacated the position in September 2006. //2008// /2009/ Rebecca Matusovich, MPPM, formerly the Prevention Team Manager in the Office of Substance Abuse within the Maine DHHS was hired in July 2007. //2009// John R. Nicholas, Commissioner of Maine's DHHS, reports directly to Governor John E. Baldacci. /2007/ Commissioner Nicholas retired in January 14, 2006. Brenda Harvey was confirmed as the new Commissioner on April 27, 2006. //2007// Dora Anne Mills, M.D., M.P.H. serves as Director of the Maine CDC and is the State Health Officer. Commissioner Harvey reports directly to Governor Baldacci. She is responsible for implementing the merger of the Departments of Human Services and Behavioral and Developmental Services into the new Department of Health and Human Services. /2009/ As part of an effort to streamline service delivery and seek administrative savings Commissioner Harvey submitted to the Governor a proposed consolidation within DHHS to reduce the number of offices from ten to six. The legislature approved the legislation. The Maine CDC will become part of HealthCare Management and Quality and Dr. Mills will report to Geoffrey Greene, Deputy Commissioner of HealthCare Management and Quality. //2009// Ms. Ricker reports to Dr. Mills. Valerie Ricker, M.S.N., M.S. is Director of the Maine CDC Division of Family Health which houses primarily direct service programs. Rebecca Matusovich, MPPM is the Director of the Maine CDC Division of Chronic Disease which houses population-based prevention and health promotion services. Richard Aronson, M.D., MPH, is the MCH Medical Director /2009/ Dr. Aronson resigned his position in January 2008. //2009// ***/2010/ Stephen Meister, M.D. was hired on March 31, 2009. //2010//*** We have 2 MCH epidemiologists, Kathy Decker, MPH and Erika Lichter, PhD. /2009/ Kathy Decker took over duties in another MCDC Division and her MCH duties were partially assumed by Cindy Mervis, MPH. //2009// ***/2010/ Denise Yob, MPH was hired in May 2008. //2010//*** The Division of Family Health continues to support a women's health coordinator position in an effort to focus attention on women's health in a more comprehensive manner. /2009/ The women's health coordinator vacated in March 2008 and a search to fill the position is underway. //2009// ***//2010// The Women's Health Coordinator position was filled in May 2009. //2010//***

/2008/ A hiring freeze continues, although to date Maine CDC has been successful in its requests for exemptions to the freeze for key positions. Maine's remote location and salaries that are non-competitive with neighboring state's urban areas continue to pose recruiting challenges for the Department. Ongoing shortfalls in the state budget pose difficulty in hiring into state positions. //2008// /2009/ The freeze has delayed filling federally funded positions. //2009// ***/2010/ A stringent freeze on all positions was in effect October 2008 through March 2009. While the hiring freeze continues, Maine CDC has been able to obtain exemptions for some key positions. Starting in March 2009 however, other on-going vacancies prevented programs from carrying out all planned activities. //2010//***

The MCH leadership has clinical training and expertise. They maintain membership with their respective professional organizations i.e. Maine Nurse Practitioner Association, Maine Chapter of American Academy of Pediatrics, and North East Rural Pediatric Association ensuring an ongoing relationship with primary care providers. Several MCH personnel are also involved in statewide and national initiatives that involve primary care.

/2008/ In April 2007 Dora Anne Mills, Maine CDC Director approved the reorganization of the Division of Family Health (FH). The reorganization groups the FH programs into 4 sections; special needs, public health nursing, community collaboration, and integrated systems development with the leader of each section reporting to the FH director. Within the next year a fifth section will be developed which will focus on operational support in the areas of finance, contract management, and grant application development. //2008// /2009/ The Population Health and Prevention section leader position vacated in March 2008 to fill a District Public Health Liaison position in the states newly emerging public health infrastructure. A process is underway to fill the position. //2009// ***/2010/ The Population Health and Prevention section leader position was filled in May 2009 by Nancy Birkhimer. //2010//***

Organizational charts indicating positions and/or programs supported with Title V funds are attached.

An attachment is included in this section.

D. Other MCH Capacity

The majority of the MCH Title V program staff are centrally located in Augusta, our State Capital. Staff classifications include: clerical support, health planners, planning and research assistants, health educators, program managers, accountants, and MCH medical director and administrative senior managers. Title V also funds 6 positions outside the Divisions of Family Health and Chronic Disease: 1 person in the Office of Data, Research & Vital Statistics; 2 in the Health and Environmental Testing Laboratory (support lead testing, sexually transmitted disease testing, etc.); 1 in the Office of Minority Health, Project LAUNCH; and 2 in the Department of Education (work with schools to develop and utilize comprehensive health education curricula). All of these positions contribute to the achievement of MCH priorities. Parents of children with special health needs form the leadership and body of the Family Advisory Council (FAC). Youth with special health needs are the body of the Young Educators and Advocators of Maine (YEA ME) Advisory with staffing provided by the CSHN Director. No staff has been hired because they are parents of CSHN although several staff members do have children with special health needs. /2008/ The recent opportunity to add a 5th delegate to Maine's AMCHP members initiated conversations to identify the most appropriate person to represent Maine families. //2008// /2009/ A young adult with special health needs and a parent of a child with special health needs have been hired through the State Implementation Grant. Each of these positions is a liaison to the larger FAC and YEA ME. The parent conducts follow-up for the Newborn Hearing Screening Program for infants identified with a refer at hospital discharge. The young adult coordinates youth-focused activities and reviews materials, from a youth perspective, for both the State Implementation Grant and the Healthy Ready To Work National Center. //2009//

The Office of Data, Research and Vital Statistics (ODRVS) provide data for this grant application, attend the MCHBG review session, and meet with the Epi Team and DFH managers for specific data needs. Our increased epidemiology capacity is leading to increased cross-divisional work between Maine CDC and ODRVS on MCH priorities. Health and Environmental Testing Laboratory staff meets regularly with the Lead Poisoning Prevention program staff and also the STD/HIV (Sexually Transmitted Disease/HIV) staff. The Department of Education (DOE) works closely with the Manager of the Coordinated School Health Program, to develop and use comprehensive health education curricula that include sexual health. We believe that by facilitating the development of citizens who understand their bodies and take ownership of their health care we have lowered our teen pregnancy rates, increased abstinence and decreased the incidence of sexually transmitted diseases. Through SSDI, CSTE and other categorical funds we have increased our epidemiology capacity. Our epidemiologists have worked closely with the DOE and other public health partners to develop a survey with multiple health indicators that will help us monitor Maine's children's health status and develop a long-term surveillance system within the Maine CDC. /2006/ The survey called, the Maine Child Health Survey (MCHS), has been administered by the Asthma Prevention and Control Program since its inception in 2002. During FY06 a plan will be developed to transition the MCHS to a more appropriate and permanent home. //2006//
/2007/ Transition planning is ongoing. The planning team agreed the MCHS would be located within ODRVS. Transition planning includes identifying the human resource to provide leadership. //2007// /2008/ Changes in Asthma and Division of Chronic Disease leadership as well as the temporary reassignment of the Title V Director prevented further movement on the MCHS in 2007. Transition planning will be a high priority in FY08. //2008// /2009/ The planning group determined that the MCHS would become part of Maine's Integrated Youth Health Survey (IYHS). The goal of this effort is to consolidate the number of schools that are asked to participate in state student health surveys and optimize school acceptance of these surveys. An RFP is currently in development that includes administration of the MCHS. Funds to conduct the survey should be awarded in Fall 2008 with an anticipated survey administration date of Spring 2009. //2009// ***/2010/ The survey was administered in Spring 2009 and analysis is underway. //2010//***

During the early 1990's support for many state funded positions was assumed by the MCHBG. A state budget deficit resulted in positions being cut if other funding sources could not be identified. Converting PHN, TYAH, Maine Injury Prevention, CSHN and Oral Health positions to federal funds facilitated maintenance of staff providing services to the Title V population. In FY02 staff salaries exceeded available federal funds. A short-term alleviation included salary savings through vacancies and medical leave, freezing vacant lines and extensive reductions in purchased supplies and materials. Long-term remediation involves generation of revenue to support positions to be accomplished through fee-for-service and targeted case management. Currently there are 5 vacancies within the programs serving the MCH population. The vacancies are within the Children with Special Health Needs, Oral Health, and Public Health Nursing Programs. Recruitment is ongoing for all vacant positions. Filling clinical positions such as PHN are particularly difficult due to low salary differences between state government and the private sector.

In addition, Title V partially supports 54 Public Health Nurses (4 supervisors and 50 field nurses) who are based statewide in 14 regional satellite offices. These nurses provide direct services via home visits, school health, immunizations, well child and specialty clinics, and participate in our program planning/evaluation. The Title V Program also has an agreement with the University of Southern Maine's Muskie School of Public Service for assistance with facilitation, training, and performance measurement, and quality improvement activities.

Senior level management include: Valerie J. Ricker, Director of the Division of Family Health, which has administrative responsibility for Title V. Ms. Ricker has 25 years of experience in MCH, 9 years with the Maine CDC as Title V Director. She has a BSN and MSN in Nursing and MS in MCH, focusing on Public Health. Dr. Richard Aronson, MCH Medical Director, has 27

years of experience in State and Maternal Child Health Programs. Dr. Aronson is a trained Developmental Pediatrician. His previous positions were with Wisconsin and Vermont State Health Agencies. He assumed the MCH Medical Director position in August 2002. /2009/ Dr. Aronson resigned his position in January 2008. A search is underway to fill the position. //2009// ***/2010/ Dr. Stephen Meister assumed the Medical Director position on March 31, 2009. Dr. Meister is a graduate of Tufts University School of Medicine. He served his internship and residency at The Children's Hospital of New York at Columbia Presbyterian Medical Center. He later was awarded a Masters in Health Services Administration from The George Washington University School of Medicine and Health Sciences. During his active duty in the US Navy, Dr. Meister served as Division Head of the Pediatric Acute Care Clinic at the Naval Medical Center in San Diego. In 2003 and again in 2007, Dr. Meister received recognition by the American Academy of Pediatrics with a Special Achievement Award for his work with the Pediatric Rapid Evaluation Program, a program developed to evaluate the medical and mental health needs of children entering foster care in Maine. Dr. Meister has been in practice as a general pediatrician for 22 years. He is the author of presentations on the assessment of stress/trauma in children and the medical needs of foster children. //2010//*** Toni Wall is the Director of the CSHN Program and has been in this position for 5 years. She has 16 years experience working in Maine CDC Programs prior to CSHN. Her past experience has prepared her to influence and manage the program. Toni holds a Masters in Public Administration with a concentration in Health Care Administration. /2006/ Dr. Erika Lichter joined the MCH Epidemiology Team in early June 2005. Dr. Lichter has an ScD in Public Health with a major in MCH and minors in Biostatistics and Epidemiology. Prior to coming to the Maine CDC, Dr. Lichter taught at the Harvard University School of Public Health. Biographical Sketches are on file in the Maine CDCs Division of Family Health and will be made available for review on request. //2006// /2007/ Cindy Mervis, MPH joined the Epi Team in July 2004. Ms. Mervis brings 13 years of experience as an Epidemiologist, many of which were with the federal CDC. Approximately 50% of her time is focused on MCH related projects. //2007// /2009/ Anthony Yartel, MPH joined the Epi Team in November 2007. Mr. Yartel was formerly with the Maine CDC Infectious Disease Division working on statewide surveillance of food-borne and vector-borne infectious diseases. His efforts will be focused on chronic disease. Denise Yob, MPH came on board in May 2008. Ms. Yob brings experience with needs assessments within a statewide network of community-based family support centers and Early Head Start sites. She also assisted in analysis for the National Evaluation of Fetal and Infant Mortality Review Programs. Her focus will be on MCH activities. //2009// ***/2010/ In February 2009 Farooq Ghour joined the Epi Team. He has a MPH and a MBBS (Doctor of Medicine). Before coming to Maine he worked as an epidemiologist and was the BRFSS coordinator at the Kansas Department of Health. He is currently working on several projects including developing a report on the health of the GLBT population in Maine, oral health surveillance, and a report on the risks and consequences of unintended pregnancy to inform the MCH Block Grant. He will continue to work on both maternal and child health and chronic disease projects. //2010//***

E. State Agency Coordination

The Maine CDC/DFH has several methods for establishing working relationships/collaboration with other entities. (Table 2 attached) We make a concerted effort to establish personal contact with others we believe to be representatives of key stakeholders in issues that involve shared populations. Others approach us when they determine that we are stakeholders in their initiatives. Finally, we convene planning groups and ask for consensus on group membership and involvement. The work of the Task Force on Early Childhood through the Humane Systems grant is exponentially creating ripples of communication among state agencies, community partners, and families. Maine Title V has been responsible for:

1. Creating a Task Force on Early Childhood of 120 varied state, community, and family representatives.

2. Developing comprehensive grant proposals for early childhood systems, women's health, integrated services
for CSHN, and implementation grant for traumatic brain injury.
3. Sharing resources and ideas for survey development.
4. Connecting the Department of Labor with Child Care Resource Development Centers to meet MCH
population needs for child care when seeking training or employment.
5. Leading ad hoc groups to study and report on the prevention of prematurity and, on early childhood as an
economic development issue.
6. Engaging, with the MCH Medical Director's involvement, the Maine Chapter of AAP participation in a family
centered survey dealing with child care in the workplace.
7. Promoting interagency training, including cultural and linguistic competence, oral health, and assets.
8. Supporting the Maine Chapter of AAP in developing a website for their organization.
9. Providing facilitation and staffing to the Interdepartmental Women's Health Committee.

The Maine CDC, Division of Family Health (DFH) continues to develop a relationship with Maine's primary care organization "Maine Primary Care Association". This organization has many competing priorities, and the former executive director did not identify MCH as a major area of focus. Their new director has experience working closely with MCH and we are anticipating an enhanced relationship with the association. The new Director, Kevin Lewis, formerly worked in Wisconsin as the Legislative Liaison for the Department of Health and Family Services. The current MCH Medical Director for Maine, who held a similar position in Wisconsin, worked closely with Mr. Lewis on a number of MCH related issues, including legislation for the Birth Defects Program. Dr. Aronson reconnected with Mr. Lewis in Maine, and they have already discussed collaboration on issues involving domestic violence, Native American health, and the fostering of primary care systems rooted in the principles of family-centered care, resiliency, and cultural and linguistic competence.

/2005/ The Women's Health Coordinator represents the DFH on the Maine Primary Care Association's Violence Against Women Governmental Affairs Planning Grant Committee. The DFH, in partnership with the Maine Primary Care Association and the Department of Behavioral and Developmental Services, submitted an application to the Maternal Child Health Bureau on a women's health grant in April 2004. The MCHB funding focused on three areas of women's health: development of comprehensive systems of services, obesity, and mental health. The DFH application focused upon the mental health area and was titled Women's Behavioral Health Systems Building: Innovative Ideas for Local and State Collaboration. Review of grants is scheduled for late June. If successful in our application this funding will assist us in continuing a focus on women's health and create new partnerships for the Division and Bureau. //2005// /2008/ Maine was successful in its' application. Activities of the grant were included in the 2006-2007 State Health Plan. The grant ends August 31, 2007. //2008//

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	22.9	22.0	23.5	18.9	18.9
Numerator	155	149	165	134	
Denominator	67628	67660	70245	70744	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 hospitalization data are not yet available. 2007 data were used as an estimate.

Notes - 2007
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Numerator = hospitalizations of children <5 years of age for which the principal diagnosis was asthma

2007 population estimate from the US Census was used as denominator

Notes - 2006
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Numerator = hospitalizations of children <5 years of age for which the principal diagnosis was asthma

2006 population estimate from the US Census was used as denominator

Narrative:
The data for this indicator are derived from Maine's Inpatient Hospital Discharge Database and population estimates from Maine's Office of Data, Research and Vital Statistics. Based on the most recent data available, the rate of hospitalization for children under age 5 was 18.9 per 10,000 in 2007. This rate is slightly lower than the 2006 rate, but since 2004, the rate of asthma hospitalizations among this population has remained relatively stable.

Through funding from the Centers for Disease Control and Prevention, the Maine Asthma Program (MAP) has been working to improve asthma management among children with the goal of reducing hospitalizations. These efforts include working with physicians in schools to increase the number of children with asthma management plans, providing community grants to increase asthma management education and providing peak flow meters to children, and training school nurses on asthma management plans. MAP received a CDC grant to continue to develop strategies to improve asthma management in the State. These strategies include enhancing Maine's asthma surveillance system, and building and evaluating partnerships.

A full-time program manager was hired in late 2007, Ruth Lawson-Stopps. Ms. Lawson-Stopps has been meeting with stakeholders across the state to develop partnerships and has updated the state asthma plan. In this plan, children are identified as a population that is disparately affected by asthma and there are several objectives related to improving asthma management among children. For example, MAP plans to work with Head Start agencies in the state to inform parents about asthma management. In addition, MAP will be working with health care centers in

areas of the state with high rates of asthma hospitalizations to increase guideline compliant care and knowledge of self-management techniques. The plan also includes objectives related to (1) improving care and the use of asthma management plans among physicians and pediatricians; (2) improving air quality and staff response to an asthma attack in schools; and (3) reducing environmental triggers in homes.

MAP has continued to be part of the Healthy Maine Partnership Initiative. This initiative provides funding to communities to address health issues that are important in their community and in the state. By funding local community-based coalitions, we anticipate increased efforts across the state to improve childhood asthma management. Maine also recently developed a local public health infrastructure to improve the health of the population. Regional public health districts have Maine CDC staff to coordinate and build community partnerships. It is anticipated that increased local public health infrastructure will lead to improvements in many health outcomes across the state, including asthma.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	86.8	86.1	89.9	88.6	89.4
Numerator	6034	6335	6494	6711	6685
Denominator	6952	7354	7221	7574	7477
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2008 indicator is for Federal Fiscal Year 2008 (10/1/07-9/30/08).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the infant had a claim.

Notes - 2007

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2007 indicator is for Federal Fiscal Year 2007 (10/1/06-9/30/07).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the

infant had a claim.

There have been several changes in MaineCare staff calculating this measure over the years; we are uncertain as to whether consistent criteria were used across the years.

It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Notes - 2006
+The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

2006 indicator is for Federal Fiscal Year 2006 (10/1/05-9/30/06).

This indicator is problematic. Due to Claims Bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, we can not accurately count the number of infants receiving EPSDT procedure codes. There is no way to tell if the service is a periodic screening for infants seen in these settings. All we can do is count whether or not the infant had a claim. The large increase in the numerator in 2000 reflects a greater understanding by Medicaid of what the data means. Specifically, starting in 2000, Medicaid pulled any claim whatsoever, while prior to 2000, it pulled claims by a combination of category of service and procedure codes. The HEDIS methodology of using 11 months of continuous eligibility is not used. The denominator is based on children determined to be Medicaid eligible on a month to month basis. If a child is eligible for any one month, he or she is counted for inclusion.The denominator increased in 2001 primarily due to increased enrollment for the Healthy Maine Prescriptions Rx Program. The Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

There have been several changes in MaineCare staff calculating this measure over the years; we are uncertain as to whether consistent criteria were used across the years.

It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
Data for this indicator are provided by Maine's Office of MaineCare Services (OMS). In FY08, 89.4% of MaineCare (Medicaid) enrollees under 1 year of age received at least one initial periodic screen. However, due to claims bundling by Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics, this estimate may not be accurate because there is no way to tell if a service received at one of these settings is a periodic screening for infants. All we can do is count whether or not the infant had a claim. This number is comparable to FY06 and FY07 data.

Overall management of the full EPSDT Program resides within the Office of MaineCAre Services. In November 2007, the informing and referral assistance component of EPSDT was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency. This component of the EPSDT Program is currently managed by Maine's Children with Special Health Needs Program. Movement of the informing and referral component into the CSHN Program provides the opportunity to influence infant access to periodic screening as well as the content of information provided to MaineCare subscribers.

Starting in Fall 2008, Maine's EPDST convened a work group of stakeholders to discuss improving Maine's EPSDT program. Maine's Director of Children with Special Health Needs and MCH Epidemiologist are part of this group, which meets on a monthly basis. The group is currently working on setting goals and objectives for the EPSDT program. The federal Centers for Medicare and Medicaid Services require that States report the EPSDT participation rates every year. We are expected to have at least an 80% participation rate but this past year Maine was at 59% participation. One of the goals of this group is to develop strategies to help MaineCare to attain the 80% benchmark participation for Maine children and youth.

The EPSDT workgroup is also trying to improve data collection on physician practice during EPSDT visits. Currently physicians who see MaineCare patients for a well-child visit are required to fill out a "Bright Futures" form. These forms include information on health history, screenings, and guidance. Starting in March 2008, all of these forms were entered into a database. Previously, only forms that required follow-up by Public Health Nurses were entered. Entry of all forms into the system will provide the Title V program with a better picture of physician practice around screening and guidance.

In addition, as part of Maine's State Systems Development Initiative application, Maine's Title V agency has started formalizing a partnership with the OMS. Through this partnership, which will lead to the use of linked MaineCare and birth certificate data, Title V will work towards increasing the number of infants who receive early screening and address the measurement of this indicator.

Finally, the Dirigo Health Plan, enacted in 2003, and other state initiatives will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	72.0	75.0	87.9	82.6	77.3
Numerator	18	27	29	19	17
Denominator	25	36	33	23	22
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2008 indicator is for federal fiscal year 2008 (10/1/07-9/30/08).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

Notes - 2007
The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2007 indicator is for federal fiscal year 2007 (10/1/06-9/30/07).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

It is difficult to interpret any differences between the 2006 indicator and indicators for prior years due to a change in MaineCare staff calculating this measure; we are uncertain as to whether consistent criteria were used across the years. There was a large percentage increase in the 2006 indicator, but this estimate is unlikely to be stable due to the small numbers. It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Notes - 2006
The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The 2006 indicator is for federal fiscal year 2006 (10/1/05-9/30/06).

Prior to the development of SCHIP, Maine's MaineCare (Medicaid) Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health

Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their Medicaid claims. With claims bundling, the Medicaid agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator. There is a significant drop in the percentage of children less than one year of age receiving at least one periodic screen in CY03. To date, the etiology of the drop has not been determined. In 1999, Medicaid blended SCHIP with Title XIX.

It is difficult to interpret any differences between the 2006 indicator and indicators for prior years due to a change in MaineCare staff calculating this measure; we are uncertain as to whether consistent criteria were used across the years. There was a large percentage increase in the 2006 indicator, but this estimate is unlikely to be stable due to the small numbers. It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This maymake comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
Data for this indicator are provided by Maine's Office of MaineCare Services. For FY08, the data indicate that 77.3% of MaineCare enrollees under 1 year of age received at least one initial periodic screen (17 out of 22 enrollees). This represents a decrease between FY07 and FY08. However, the small number of infants enrolled in SCHIP may cause this estimate to vary substantially over time.

Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP Program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. Rural Health Centers, Federally Qualified Health Centers, and ambulatory hospital based clinics are permitted to bundle their MaineCare claims. With claims bundling, the MaineCare agency is unable to specifically count the number of persons receiving EPSDT procedure codes, as there is no way to determine if the service was a periodic screen. We believe this results in under reporting for this indicator.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population. Maine's State System Development Initiative will also help monitor infant receipt of periodic screens by allowing Maine's Title V agency to access linked birth certificate and Medicaid data.

Finally, the Dirigo Health Plan will hopefully increase this indicator as a result of more people having access to health insurance which includes coverage of preventive health services such as well child checks.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	86.9	87.5	87.1	86.5	84.7
Numerator	12074	12316	12297	12163	11506
Denominator	13899	14072	14121	14068	13582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data from this measure are from Maine's 2008 electronic birth certificate database from Maine's Office of Data, Research and Vital Statistics.

Notes - 2007
Data from this measure are from Maine's electronic birth certificate database from Maine's Office of Data, Research and Vital Statistics.

Birth certificate data on this measure are similar to 2007 PRAMS data. According to PRAMS, 84.8% of women reported greater than or equal to 80% prenatal care on the Kotelchuck Index.

Notes - 2006
The data source for this measure comes from Maine's electronic birth certificate database.

Data from Maine's 2006 PRAMS survey reveal a very similar value; 87.5% of women surveyed had adequate prenatal care.

Narrative:
Data on prenatal care are derived from birth certificates provided by Maine's Office of Data, Research and Vital Statistics. In Maine, 84.7% of women with a live birth in 2008 received at least adequate pre-natal care (as defined as 80% on the Kotelchuck Index).
Since 2003, Maine's estimate on this indicator has remained fairly stable with adequate prenatal care estimates ranging from 83.8%-87.5% during this time.

Maine's Title V Program is working on improving the adequacy of prenatal care in the State through ongoing monitoring efforts. Maine has had the Pregnancy Risk Assessment Monitoring System in place since its inception. These data provide valuable information on women's pre and post pregnancy behaviors. In addition, Maine's Title V Program examines and publishes data on pre-natal care and birth outcomes using birth certificate data. Through Maine's SSDI grant, Title V will begin working with MaineCare to link birth certificate and MaineCare data to examine birth outcomes in relation to pre-natal care. By examining these data and disseminating the results statewide and to local communities, we hope to increase the percent of women in Maine receiving adequate prenatal care. Title V also works very closely with WIC, which is part of the Family Health Division of Maine CDC, where Title V resides, to encourage women enrolled in WIC to obtain prenatal care.

Efforts to improve prenatal care include 1) Maine's Home Visitation Program, which now has a contracting performance measure related to the percent of prenatal enrollments into the home visiting program; 2) The Perinatal Substance Abuse Collaborative Project, a vibrant multi-disciplinary group that addresses systems issues such as ensuring a non-punitive approach to the new neonatal drug exposure reporting law and establishing standards for breastfeeding among women taking Methadone; 3) The Humane Systems for Maine Early Childhood Plan, which has several recommendations related to prenatal care, and 4) The start of the Maternal

and Infant Mortality and Resiliency Review (MIMRR) Panel, funded by the Maine March of Dimes with a unique focus on incorporating resiliency into the reviews.

In addition, in 2008 Maine was awarded a grant through SAMHSA to address unmet child health needs between the ages of prenatal to 8 years of age in Washington County. This "Project LAUNCH" grant demonstration site (Community Caring Collaborative) in Washingtonis working with pregnant women who are at risk for a preterm birth and/or a prolonged hospitalization due to neonatal abstinence syndrome. One of the initiatives is a pre-delivery visit by the mother, her support person and one of her Washington County based service providers to the Eastern Maine Medical Center (EMMC) neonatal intensive care unit. This visit prepares the mother for the potential needs of her baby in the postpartum period as well as familiarizes her with EMMC staff, starts hospital discharge planning including follow up visits. This is done in order to facilitate positive bonding between the mother, her baby and her immediate support system. Women are identified in the prenatal period through existing health care and support programs as well as through Discovery House, a narcotic treatment facility in Calais, Maine.

As part of the development of Maine's local public health infrastructure, communities will be conducting health assessments to examine the health of their population. Many MCH indicators, such as pre-natal care, will be included in these assessments. These assessments will help guide community efforts, and could help prompt more local level initiatives designed to improve the adequacy of prenatal care in the state. In Fall 2007, district-level health profiles were released to provide regional-level data to Maine's new public health infrastructure.
http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm
These profiles included data on the percent of women receiving prenatal care in the 1st trimester by district and showed statewide racial and ethnic disparities in accessing early prenatal care. These profiles have been widely distributed across the state. By raising awareness of key MCH-related health issues in individual districts across the state, such as adequate prenatal care, Maine's Title V Program hopes to work more closely with communities to improve this indicator.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	81.3	81.6	94.0	94.2	92.9
Numerator	111523	113657	124443	125159	124443
Denominator	137134	139367	132322	132805	134015
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2008 indicator is for Federal Fiscal Year 2008 (10/1/07-9/30/08). Indicator is for 1-21 year olds.

Notes - 2007
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2007 indicator is for Federal Fiscal Year 2007 (10/1/06-9/30/07). Indicator is for 1-21 year olds.

In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Notes - 2006
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2006 indicator is for Federal Fiscal Year 2006 (10/1/05-9/30/06). Indicator is for 1-21 year olds.

In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
According to Maine's Medicaid office located within the Office of MaineCare Services, 93% of MaineCare eligible children received a service paid for by the MaineCare Program in FY08. This is approximately the same percent as was reported for FY06-FY07. Between 2001-2006, the percent of MaineCare eligible children who have received a service from MaineCare steadily increased indicating that more children who are eligible for services from MaineCare were receiving them, but has leveled off in recent years.

As mentioned under HSCI # 02, in November 2007, the informing and referral support component of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to the Division of Family Health, home of Maine's Title V agency. This component of the EPSDT Program is currently managed by Maine's Children with Special Health Needs Program. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population.

Maine's Office of MaineCare Services has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT services. This group was convened in September 2008 and continues to meet on a regular basis. One of the goals of this group is to develop strategies to help MaineCare in attaining the 80% benchmark participation for Maine children and youth as required by federal CMS.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	45.4	40.1	43.0	44.6	48.1
Numerator	11333	7825	8582	11786	12799
Denominator	24939	19534	19972	26421	26610
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

2008 indicator is for federal fiscal year 2008 (10/1/07-9/30/08).

Notes - 2007
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

2007 indicator is for federal fiscal year 2007 (10/1/06-9/30/07).

It is important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Notes - 2006
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

2006 indicator is for federal fiscal year 2006 (10/1/05-9/30/06).

Maine care staff calculating this variable have changed several times over the years; we are uncertain as to whether consistent criteria were used across the years. It is also important to note that the MaineCare data system was changed during FY06 due to problems with old system. This may make comparisons between 2006 and 2005 data difficult to interpret. In January 2005, the MaineCare (Medicaid) Management Information System, referred to as the Maine Claims Management System (MeCMS) went "live," but had several problems with claims processing. Performance of the system was volatile during spring and summer of 2005. Significant improvement occurred in the months following June 2005. Therefore, it is difficult to interpret the increase in the percent served by Medicaid in the 2006 indicator. It may be a reflection of improved data quality rather than an increase in services.

Narrative:
The Office of MaineCare Services reported that 48.1% of EPSDT eligible children aged 6-19 received any dental services within FY08. The percent has increased over time since 2006. It is difficult to interpret any differences between the 2006 indicator and indicators for prior years due to a change in MaineCare staff calculating this measure; we are uncertain as to whether consistent criteria were used across the years.

The Maine Oral Health Program (OHP) continued to fund and coordinate the school-based/school-linked School Oral Health Program (SOHP); for the 2007-2008 school year. There were 79 grants to schools, school districts and several community agencies throughout the state, providing oral health education and dental screening in 242 participating elementary schools. Children in many schools participate in a weekly fluoride mouthrinse program, and in about half of all participating schools, second graders may receive dental sealants at school. School eligibility for the SOHP is determined by a formula that includes the proportion of students eligible for the Free and Reduced Lunch Program and for MaineCare as well as the proportions of the community receiving fluoridated public water and whose family income is at the federal poverty level. In this way, the SOHP is directed toward those communities and schools where children are more likely to have problems with accessing dental services, since socio-economic status is directly related to the ability to obtain dental care. Local SOHP directors, the majority of whom are school nurses, work to assure that children who may be eligible for MaineCare do enroll; they also often work within their communities to find dental care for children who do not have a regular source for that care. In the biennial budget for SFY10 and 11, funding from the state General Fund that has supported the SOHP was reduced by $250,000, leaving $127,816 to fund the SOHP and provide for certain operating costs; for SFY10, an offset to this cut will be made using other available but one-time only funds. As a result, eligibility for grants for the 2009-2010 school year was critically reviewed and grants will be made for one year only rather than the usual 5 year grant cycle. It is unclear how the SOHP will be sustained without significant restructuring and downsizing after SFY10.

Staff participate on MaineCare's Dental Advisory Committee reviewing proposed policy and administrative changes that may increase access to dental services for children.

As mentioned under HSCI # 02, in November 2007, the informing and referral assistance components of Maine's EPSDT Program was shifted from within the Immunization Program in Maine CDC's Division of Infectious Disease to Maine's Title V agency. Through this component of EPSDT, Maine's Title V agency will be better able to influence the content of the information provided to this population regarding EPSDT eligible infants and dental services.

Maine's Office of MaineCare Services has initiated a monthly meeting of stakeholders to develop goals for Maine's EPSDT program, which will include increasing the number of children who receive EPSDT services. This group was convened in September 2008 and continues to meet on a regular basis. A representative from Maine's Oral Health Program is a member of this group.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.1	0.3	0.4	0.3	0.2
Numerator	30	9	12	9	5
Denominator	2776	2821	2938	3096	3080
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program stopped serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare

Notes - 2007
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program is no longer serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare.

Notes - 2006
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

This indicator has decreased as the CSHCN program is moving from a direct service program to actively building a community-based system of care. As of July 1, 2005, Maine's CSHN Program is no longer serving clients who receive all of their services through MaineCare (Medicaid). Since the SSI population automatically receive MaineCare, this population has been reduced. The CSHCN program serves only those SSI beneficiaries whose needs cannot be met through MaineCare.

Narrative:
The CSHN Program currently serves 513 infants, children and adolescents ages 0 -- 21. Based on data from Maine's Children with Special Health Needs Program, 1% of SSI beneficiaries under age 16 received services from Maine's CSHN program. This is due to the CSHN Program no longer serving (as of July 1, 2005) those clients who receive all of their services through MaineCare. Since the SSI population automatically receives MaineCare this population has been reduced.

As of December 2008 the Social Security Administration reported that 3,080 children under the age of 16 were receiving SSI. During FY07 the Maine CSHN Program served 5 of these children. The reduction in the number of children served is a result of the CSHN Program moving from direct service to a focus on building infrastructure and capacity to serve a larger number of children with special health needs. This fundamental change will allow the program to serve a greater number of children receiving SSI by assisting the medical home to first identify those children on SSI and assure their needs are being met through care coordination activities.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	other	7.1	6.2	6.7

Notes - 2010
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2008.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2008.

Non-Medicaid: Calculated by subtracting the Medicaid number of low birthweight babies from the All number of low birthweight babies and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

Maine's Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. Another potential data source for this indicator is the 2006 PRAMS survey, which found that 6.0% of MaineCare births were low birthweight, compared with 5.3% of non-MaineCare births and 5.7% of all births statewide.

Narrative:
Maine has put a great deal of energy into expanding eligibility for MaineCare and simplifying the enrollment process. MaineCare incorporates the Child Health Insurance Program (CHIP). It covers pregnant women and children birth through 18 up to 200% of the federal poverty level.

It is important to note that the data presented for the non-MaineCare population include those who are uninsured, as well as those who have private insurance. The percent of low birth weight babies among MaineCare enrolled infants is higher than those not enrolled in MaineCare. In addition, those insured through MaineCare appear less likely to start prenatal care in the 1st trimester and have adequate prenatal care, as defined by the Kotelchuck Index. The 2007 data suggest that infant mortality rates are better among those receiving MaineCare compared to non-MaineCare. However, we are working with the MaineCare analysts to determine how we can better identify infant deaths in the Medicaid Data System. MaineCare's data analyst currently conducts a manual search in the Medicaid data for infants who died using a list provided by the Maine Vital Records Office. This year we have put in a formal request for a linked infant birth/death file that we will link with MaineCare data to allow for better identification of infant deaths among those enrolled in MaineCare.

This year we conducted a Perinatal Periods of Risk (PPOR) analyses using data from 2001-2005. Results from this analysis revealed that the highest rate of excess deaths occurred among infants 500-1499g and those 1500+ who died in the neonatal period. The results were presented to the Maine Maternal and Infant Mortality Panel. In the next year, we plan to expand the PPOR analysis and use the results to inform the 2010 Maine MCH Strengths and Needs Assessment. We plan this year to conduct more in-depth analyses of infant mortality data to inform this indicator.

Collaborations with MaineCare on understanding the differences within HSCI #5 have allowed us to understand the complexity of MaineCare -- how, for example, the MaineCare population includes a heterogeneous mix of recipients who qualify through multiple categories; and how the

way that MaineCare defines eligibility (one month versus 11 month enrollment in a given year) significantly affects the indicators. At the same time, by working together, MaineCare has learned from Title V that MaineCare enrollment itself does not translate into full access to a Medical Home for a recipient. Through Maine's SSDI grant, we plan on increasing collaborations between Title V and MaineCare to better understand these differences and work towards improving this indicator.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	3.4	9.3	6.2

Notes - 2010

Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2008. MaineCare manually matched the names on a list of infant deaths (provided by the Office of Data, Research and Vital Statistics at the Maine CDC) against the MaineCare database. Due to the manual match technique used, it is likely that some deaths were missed. The low number of infant deaths in the state each year also makes this comparison difficult to interpret.

Non-Medicaid: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2007. Mortality data are not yet available for 2008.

All: Calculated by subtracting the Medicaid number of infant deaths from the All number of infant deaths and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

Narrative:

An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	83.2	90.9	86.8

Notes - 2010
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2008.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2008.

Non-Medicaid: Calculated by subtracting the Medicaid number of infants born to pregnant women receiving prenatal care starting in the first trimester from the All number of infants born to pregnant women receiving prenatal care beginning in the first trimester and dividing that by the number of All live births minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year), this figure is a rough estimate, rather than an actual value.

Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. Another potential data source for this indicator is the 2007 PRAMS survey, which found that 88.7% of women enrolled in MaineCare received prenatal care during the first trimester, compared with 96.8% of women who were not enrolled in MaineCare and 92.7% of women statewide.

Narrative:
An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	74.8	95.9	84.7

Notes - 2010
Data sources:
Medicaid: Data are from the Office of MaineCare Services, using the MaineCare data system, and are for federal fiscal year 2008. The statistic is calculated including all births. It is not restricted to only women age 15-44.

All: Data are from the Office of Data, Research and Vital Statistics, Maine CDC, using birth certificate files, and are for calendar year 2008. Data are restricted to only those age 15-44.

Non-Medicaid: Calculated by subtracting the Medicaid number of pregnant women with adequate prenatal care from the All number of pregnant women with adequate prenatal care and dividing that by the number of All women giving birth minus the number of Medicaid live births. Due to the different time periods for which data were available from these two sources (federal fiscal year vs. calendar year) and slightly different denominators (women giving birth vs. live births; age

differences), this figure is a rough estimate, rather than an actual value.

Office of MaineCare Services staff have indicated that there are some concerns about the birth information in the MaineCare data system. As such, we also present the following values from the 2005 PRAMS survey:
"Medicaid" population: 84.8%
"Non-Medicaid" population: 92.4%
"All" population: 88.5%

(Note: For the PRAMS analysis, a woman was considered to be in the "Medicaid" population if she reported that she was enrolled in Medicaid/MaineCare just before pregnancy or that Medicaid/MaineCare was one of the payers for her prenatal care or delivery.)

Narrative:
An overall discussion of HSCI 05 can be found under HSCI 05A.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
In Maine, SCHIP is combined with MaineCare. Together, these programs cover infants, children and pregnant women up to 200% of the federal poverty level. Prior to the development of SCHIP, Maine's Medicaid Program covered infants up to 185% FPL. With the addition of the SCHIP program, coverage was expanded to cover infants between 185% and 200% of FPL. This translates to a small number of infants. In 1999, MaineCare blended SCHIP with Title XIX.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 150 150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5)	2008	 200

(Age range 6 to 19) (Age range to)		200

Narrative:
An overall discussion of HSCI 06 can be found under HSCI 06A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Narrative:
An overall discussion of HSCI 06 can be found under HSCI 06A.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects	3	Yes

surveillance system		
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Maine has a State Systems Development Initiative in place to help increase the capacity of the Maine Title V Program to have access to policy and program relevant information and data. Maine's SSDI grant has helped to increase the epidemiology capacity of the Title V Program to allow us to support the Title V Program and analyze data for the MCH Block Grant. A doctorate-level MCH epidemiologist was hired in 2005 and three masters' prepared epidemiologists are currently involved with MCH programs. The SSDI initiative also helped Maine's Title V Program complete the Comprehensive Strengths and Needs Assessment for the 2005 Block Grant. In December 2006, Maine's Title V received continued SSDI funding. Through this grant, the Title V Program is working on increasing its data capacity by: (1) linking WIC and birth certificate data and MaineCare and birth certificate data, (2) enhancing the birth defects surveillance system, (3) developing a database for a new Maternal and Infant Mortality and Resiliency Review Panel, and (4) supporting the development and sustainability of school health surveys. In addition, we again plan to use the funds to conduct a comprehensive strengths and needs assessment to inform the 2010 MCH Block Grant. Planning for this effort is underway.

In addition, funding from the State Systems Development Initiative has allowed us to explore our existing data sources to inform program policies and activities. For example, we have conducted in-depth analyses of Maine's linked birth-infant death database to examine in more detail the demographic and systems-level characteristics associated with infant mortality in the state. These analyses will inform the work of Maine's new Maternal and Infant Mortality and Resiliency Review Panel. In addition, we have built a relationship with the Office of MaineCare Services to access MaineCare data for key MCH indicators. We are also working with the University of Maine to enhance the usability of Maine's ChildLink system, which includes infant birth and death data, newborn hearing, newborn screening, and birth defects. This past year, we also started examining linked data systems in other states to build Maine's data linkage capacity.

In 2009, Maine administered the Maine Integrated Youth Health Survey. This ambitious survey includes questions from the Youth Risk Behavior Survey, Maine's Youth Drug and Alcohol Use Survey, as well as other questions added by programs within the Maine CDC, including many MCH-related programs. High school, middle school, and elementary school versions were created and distributed. Many of the questions on these surveys will inform MCH programs. Data on many items will be available at the local level, which will help community-based MCH efforts. The survey is coordinated by the director of the Maine CDC's Teen and Young Adult Health Program and SSDI funding will be used to ensure data quality and for analysis. The survey has achieved over a 60% response rate and the data will be available by the end of 2009.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Maine Youth Drug and Alcohol	3	Yes

Use Survey/Youth Tobacco Survey		

Notes - 2010

Narrative:
Maine has several data systems in place that allow us to monitor tobacco use among youth in grades 9-12. Between 1995-2007, Maine administered the Youth Risk Behavior Survey (YRBS) to middle school and high school students biennially. The YRBS is a statewide representative sample of youth and includes several questions on tobacco use in the past month and during the lifetime. Starting in 2002, in alternate years, all high schools and middle schools in Maine were invited to participate in the Maine Youth Drug and Alcohol Use Survey (MYDAUS)/ Youth Tobacco Survey (YTS). This survey included detailed questions about substance use, including tobacco, within the past month and during the lifetime. Data for both the YRBS and MYDAUS/YTS are available online. Schools that participated in the MYDAUS/YTS are able to access school-level data online as well.

In Spring 2009, Maine administered the Maine Integrated Youth Health Survey. This survey includes question from the Youth Risk Behavior Survey, Maine's Youth Drug and Alcohol Use Survey, as well as other questions, including many on tobacco use. High school, middle school, and elementary school versions were created and distributed. The high school survey includes several questions on tobacco use within the past 30 days, including the use of cigarettes, cigars, and chewing tobacco. The survey has achieved over a 60% response rate and the data will be available by the end of 2009.

Maine has seen dramatic drops in adolescent tobacco use in recent years, showing a 60% decrease over 8 years. These drops can be attributed to a comprehensive approach that includes: (1) Maine adequately funding tobacco control and prevention, one of only six states to meet the CDC's minimum funding recommendations, (2) restricting youth access to tobacco products, through enforcement of laws and tobacco-free schools policies, (3) smoke-free environments, including restaurants and bars, and (4) high tobacco taxes.

An in-depth analysis of 2001-2007 Youth Risk Behavior Survey tobacco questions was recently conducted for Maine's Tobacco Program. Results revealed that smoking has declined in high and low risk youth, but there has been a greater relative decline in the lower risk population. These results provide evidence for a concentration of smoking in high risk youth and encourage collaborative strategies between programs within the health department to reduce smoking as well as other high risk behaviors (e.g., suicide ideation, risky sexual behavior). These analyses have been incorporated into a paper that will be submitted for publication.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Maine is unique for a number of reasons. Geographically, Maine's land area is the size of the other 5 New England states combined. It is divided into 16 counties and has 3 large cities, Portland, Lewiston-Auburn and Bangor. Maine has a population of 1.3 million people (2008 estimate), 2/3 of whom live in the southern third of the state. (See Section III A for more detail.) The state has a long history of local civic engagement. It has an independent, can-do spirit that fosters cooperation regardless of political beliefs. Towns continue to be the core of Maine's governmental structure in which roughly 344 of the 454 towns and cities maintain the direct democracy, town meeting format of government. County government, on the other hand, is weak.

Maine's state bureaucracy remained relatively small and underdeveloped until the 1970's and 1980's, when many federal responsibilities were transferred to the states, including Title V. In a widely published 1983 report to the National Governors' Association (America's Children: Powerless and in Need of Friends), Maine's Department of Health and Human Services provided a compelling argument for why the unmet needs of our nation's children require governmental and societal support. Maine's public health system, including MCH, was built upon this structure. Most public health functions are concentrated at the state level. While the two largest cities (Portland and Bangor) have local public health departments, the state does not have any county health departments. The Maine CDC's Public Health Nurses, public health educators, health engineers, and restaurant inspectors provide the local public health presence. The State's capacity to perform many categorical public health functions is extended through contracts with private health care providers and community-based organizations. /2006/ In the past six years several proposals have been made to address the lack of a more locally based public health presence. Maine received a Robert Wood Johnson, Turning Points Grant, which provided a vehicle for convening the public health related community to design plans for a Regional Public Health System in Maine. Legislation for such a structure was submitted in the 1st year of the 121st Legislative Session. At the same time the Governor's Office put forth legislation for the Dirigo Health Plan which addressed many of the issues in the Turning Points legislation. It was agreed to hold the Turning Points legislation until the Dirigo Health Plan was implemented and its implementation could be evaluated. The Governor's Office of Health, Policy, and Finance is leading the discussion regarding Regional Public Health Infrastructure. The Public Health Workgroup (PHWG) was convened in 2005 and charged with outlining a regional structure.

/2008/ Maine's State Health Plan for 2006-2007 included objectives to build a statewide public health infrastructure for the purposes of improving efficient and effective public health capacity and the delivery of the 10 essential public health services and 3 core functions of public health statewide. The emerging infrastructure includes a statewide network of Comprehensive Community Health Coalitions; an enhanced Local Health Officer system; eight districts, each with a District Coordinating Council (DCC) and Maine CDC Public Health Units located in DHHS regional offices; existing Tribal and Municipal Health Departments, and Maine CDC and Office of Substance Abuse in the DHHS. The emerging public health system will coordinate with and build upon the strengths of existing infrastructure that includes health care and education systems, family planning and maternal child health systems, other non-profit organizations, emergency management, and other regional and local government entities. The eight districts are based on county lines and are as follows: Aroostook; Cumberland; Penquis; Downeast; Midcoast; Central Maine; Western Maine; and York. The districts were chosen based on population, geographical spread, county borders and hospital service areas. The eight public health districts are the same configuration as those used by the district court system and tourism bureau. The Maine DHHS recently adopted the same district boundaries and is implementing them within the child welfare and mental health sections within DHHS. Public Health Units of the Maine CDC will eventually be aligned to serve these districts. Each district will be expected to convene DCCs as a collaborative interface between local and state public health entities. The DCC's will help assure coordinated,

effective and efficient public health delivery in each district. They will also be responsible for developing district health improvement plans and their planning will contribute to the State Health Plan as well as local health planning efforts. //2008// /2009/ The PHWG completed its planning work and submitted a final report "Current Plans and Recommendations for a Statewide Public Health Infrastructure to be Developed Within Existing Resources Over the Next Five Years". (http://www.maine.gov/dhhs/boh/phwg/index.htm#report).
A statewide Coordinating Council (SCC) was formed and will replace and build upon the work of the PHWG to implement a statewide public health infrastructure that assures a more coordinated system for delivery of public health services. A search was conducted and the Director of the Office of Local Public Health (OLPH) and 3 of the 8 District Public Health Liaison positions were filled (York, Western Maine and Midcoast). All central level OLPH staff will organize services in the remaining districts until the liaison positions can be filled. OLPH activities to date include: setting up the OLPH, hiring 2 additional District Public Health Liaisons by summer 2008, developing a Local Health Officer Training, forming DCC's in all districts, and providing assistance to the Healthy Maine Partnerships around the Mobilizing for Action Through Planning and Partnerships (MAPP) assessment process. //2009// ***/2010/ Funding constraints have prevented filling the remaining 5 District Public Health Liaison positions. The existing 3 positions continue to coordinate all activities with the DCCs in the other districts. MAPP assessments are underway in the districts; 5 have been completed with the remaining 3 to be completed by October 2009. Districts will utilize the results of the assessment to develop a health improvement plan. //2010//***

Looking at the conceptual framework for the services of the Title V MCHBG, Maine's resources have fallen more heavily within the Direct Services area resulting from the state's local limited resources. However, over the past nine years, under the direction of Valerie Ricker, the Title V Program has shifted its priorities from primarily funding direct MCH services to also supporting efforts and projects that promote the development of family-centered MCH systems of services and care. The emphasis has shifted from relying on the MCH Block Grant for direct service provision to using it as an innovative planning and system building tool and to implement a view of child and family health within an interlinked ecological context. The interlinked ecological context refers to the role of environments at the family, neighborhood, community, state, and societal levels in promoting better health and developmental outcomes. Thus, we have adjusted the balance of human and financial resources so that they are more in alignment with Title V's role in strengthening public health capacity and infrastructure at the local and regional level. The beauty of Title V is that it gives states the flexibility to adjust their role and function to that of placing a greater focus on core public health functions and quality assurance in relation to direct services provided at the local and regional level. Maine's Title V activities, by level of the pyramid for the MCH population, are summarized in the attached table.

An attachment is included in this section.

B. State Priorities

The Maine MCH Title V Program uses the 1988 Institute of Medicine definition of public health as the process of assuring the conditions in which people can be healthy. The Maine Title V Program is rooted in the vision that families and communities, and our state as a whole thrive when children of all ages enjoy optimal health; feel physically and emotionally safe; are treated with dignity and respect; enter adulthood equipped with intense curiosity about the world, a deep desire to learn, a resilient spirit, and a healthy balance of cognitive and emotional skills; and have a sense of purpose, hope, and power about their lives, so that they can become compassionate and productive individuals.

The priorities selected for the next five years were developed based upon the in-depth analysis of the health of the MCH population through quantitative and qualitative data. While the priorities are listed as 1-10, this does not mean that number 1 has a higher rating than 10. From the Title V Program perspective, they are all of equal value. The priorities are very broad in nature. This

was intentional in that all people who work with and care about the MCH population have a stake in working together in a synergistic way on achieving these priorities. Also, while the MCH Block Grant is the fuel that drives our leadership, the MCH Title V Program is much more than the Block Grant itself. In addition, we decided to word the priorities in positive phrases such as improve, increase, and foster conditions to reflect our commitment to measuring strengths as well as needs.

Although the priorities are broad, they are more specific than the priorities selected in 2000. The 2000-2005 priorities were more focused upon how we would achieve our work and a couple of specific health priorities. The 2005-2010 priorities identify specific areas of health, but at the same time are broad enough to ensure inclusion of the whole MCH population in focused activities and in all aspects of a priority. We felt that too much specificity would jeopardize the obvious importance of many issues not making the list, and give the false impression that we favor addressing only certain segments and age groups of the MCH population.

The 10 priorities and rationales are as follows:

1. Improve Birth Outcomes

While Maine does better on many birth outcomes than does the nation as a whole, the state has not yet met many birth-related Healthy People 2010 and Healthy Maine 2010 objectives, and the proportion of premature births has increased significantly during the past decade. We view the following objectives as examples of what we intend to address for achieving this priority: reductions of prematurity, low birth weight, and perinatal morbidity and mortality, including perinatal substance abuse; reductions in teen pregnancy; and increases in social support for pregnant women and early prenatal enrollment for WIC and home visiting.

2. Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries

Unintentional injuries are the leading cause of death for 1-19 year olds and the second leading cause of death for women ages 20-44 in Maine. Unintentional injuries also are one of the most common principal diagnoses of hospitalizations among these groups. Suicide is the second-leading cause of death among 15-24 year olds and the fourth leading cause of death among women ages 20-44 in the state. The definition of safety encompasses physical, psychological, and emotional safety and includes a public health approach to the prevention of violence. Injuries range from those sustained in automobile crashes or falling off the equipment at the playground to those intentionally inflicted by another or by oneself. The ability of our families and children to feel safe at all times is paramount and this can only be accomplished through a variety of mechanisms to include a wide variety of violence prevention, including domestic, physical, sexual, child abuse and neglect, bullying, suicide and poisoning prevention initiatives.

3. Improve the respiratory health of the MCH population

Almost 1 in 11 kindergartners in Maine have asthma, as do nearly 1 in 8 women ages 18 and older. Only 37% of kindergartners with asthma have a written management plan. Asthma also is one of the most common principal diagnoses in hospitalizations of 1-9 year olds in the state. Smoking, and second-hand smoke affect the respiratory health of a large proportion of the MCH population in Maine. Research has shown that children are able to learn and adults are more productive if living and working in healthy environments. We feel this can only occur if we support efforts that include the reduction of environmental [indoor and outdoor] hazards, such as first and second hand smoke, mold, and smog; and the reduction of the incidence and burden of asthma.

4. Increase the proportion of the MCH population who are at a healthy weight and physically active

Large segments of the MCH population in Maine are overweight or at risk for overweight. The problem begins in early childhood (where 16% of 2-4 year olds enrolled in WIC are overweight and another 17% are at-risk-for-overweight) and continues through adulthood (where nearly half of women aged 18 and older are at risk for health problems related to being overweight). In addition, significant proportions of the Maine MCH populations are not physically active. For all our children, including CSHN and people with disabilities, to thrive and be healthy and happy they need to engage in physical activity and have access to information on nutrition as well as nutritious food. This is an area that a wide range of partners in public health can contribute to both individually and collectively.

5. Improve the mental health system of services and supports for the MCH population

Mental disorders affect a large proportion of the MCH population in Maine. For example, these disorders are one of the most common principal diagnoses for hospitalizations among Maine children ages 5-19 and Maine women 20-44 years old. One study estimated that 1 in 6 rural Maine children has a behavioral health problem. One in four high school students reported feeling so sad or hopeless for 2 or more weeks in a row that they stopped doing some usual activities. More than half of all new mothers in the state reported at least some degree of postpartum depression. Mental health and the lack of available services, as well as family stress, were identified as key needs by dialogue group participants. When we use the word mental health, we are including all aspects of social, emotional, and behavioral health as important components of the mental health system. It is time to formalize the reality that mental health is integral to MCH. Research indicates that a large percentage of children with the most significant behavioral and emotional symptoms never receive any services at all. A lack of licensed clinicians and psychiatrists results in primary care physicians having to provide services. Through enhanced partnerships with our colleagues in mental health at the state and local level, and through such initiatives as the Behavioral Women's Health Grant, Early Childhood Comprehensive Systems Grant, and the Harvard Prevention Resource Center we will aim to integrate mental health into primary health for the MCH population.

6. Foster conditions to improve oral health services and supports for the MCH population

Our state's large geography coupled with a shortage of dentists has resulted in large numbers of the MCH population lacking adequate dental care. Dialogue group participants identified the lack of dental care resulting primarily from a demand that exceeds the number of providers as a key issue in the state. Poor oral health can and does impact the overall health of individuals. We will work to support efforts that enable increased access for our children and families to integrate oral health into primary health care and schools for the MCH population.

7. Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based
system of care that enables the whole CSHN population to achieve optimal health

CSHN must have the opportunity to achieve their optimal potential in all areas of health and development. We can be much more successful in this effort through systemic change that uses a public health approach to serving this population. Our challenge is to transform our CSHN Program so that it aims to put into practice systems of care that support family-centered and culturally and linguistically competent service in all communities for all children with special health needs.

8. Foster conditions to expand the medical home model to a comprehensive health home system for the entire
MCH population

We know that the quality of life for families improves when obstacles to needed services and resources are removed. Our care coordination approach, as currently incorporated into the

medical home model for children with special health needs, is an example of what we should make available to the whole MCH population. A Health Home includes but goes beyond the Medical Home. It is rooted in our vision of health and includes the physical, mental, emotional, and spiritual realms of the person and family. It represents a standard that we will aim to make available for all children in our state.

9. Improve cultural and linguistic competence within the system of services for the MCH population

It is essential that we honor and respect the culture and language of all children, families, and communities in Maine; and that we incorporate cultural and linguistic competence into every aspect of MCH in Maine. Such an approach is necessary in aiming to move toward the Healthy People 2010 objective of 100% access to health care and zero disparities in health status for all citizens. It depends on the capacity of all of our health and human systems, including education, childcare and mental health, to deliver culturally and linguistically competent care and services. Dialogue group participants felt that Maine is not yet doing a very good job of supporting issues of diversity and culture and that this is an important issue to address. We will begin this process by first conducting an assessment of cultural and linguistic competence within the Title V Agency and MCH supported agencies, and identify goals and actions for improvement. We will use these self-assessments to work with our partners on areas of improvement.

10. Integrate existing services and supports for adolescents and young adults into a comprehensive system
that draws upon their own strengths and needs

To foster life-long healthy habits and health, youth need services, supports and opportunities. Health care services, including oral and mental health care, must be provided where young people are and be sensitive to the unique concerns and barriers that they face. Supportive environments and adult allies can help them develop competencies and connections that help prevent unhealthy risk behaviors and promote overall health. Actively partnering with youth in meaningful ways fosters conditions for successful endeavors and continued participation.

The Maine Title V Program has selected 7 performance measures related to the above priorities. We anticipate over the next two to three years we will develop one to three additional measures related to the 10 priorities. Areas under consideration for developing future state performance measures include: tobacco use in pregnancy, mental health, cultural and linguistic competence, early childhood, child abuse, and something state specific related to asthma. /2007/ Child care health consultants play a critical role in promoting healthy and safe child care environments and supporting education for children, their families, and child care providers. This support specifically includes children with special health needs. Child care consultants also improve access to preventive health services such as medical and dental homes, early intervention and family support. During the past year Maine along with 5 other Region 1 states worked collaboratively to create a developmental state performance measure beginning in FY07 to increase the number of licensed child care providers that receive annual visits from a child care health consultant. The new measure is; "The percent of licensed child care centers serving children age birth to five who have on-site health consultation". This measure is consistent with recommendations from the AAP, APHA, and MCHB/HRSA. //2007// The performance measures selected for Maine are:

1. The percentage of births in women less than 24 years of age that are unintended.
2. The percentage of 0-11 month old children enrolled in WIC who were ever breastfed.
3. The motor vehicle death rate per 100,000 among children 15 to 21 years of age.
4. The percentage of high school students (grades 9-12) who are overweight.
5. The percentage of high school students (grades 9-12) who feel like they matter to people in their community.
6. The percentage of elementary schools that have developed and implemented a

comprehensive approach to
the prevention of bullying in collaboration with the Maine Injury Prevention Program.
7. The rate per 1,000 of emergency department visits for asthma among women ages 15-44.

/2007/
8. The percent of licensed child care centers serving children age birth to five who have on-site health
consultation. //2007//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	21	26	24	18	32
Denominator	21	26	24	18	32
Data Source					Maine Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center). Data are from Maine's Newborn Screening Program.

Starting July 1, 2008, Maine started screening for cystic fibrosis. Since the implementation of this screening test 6,906 infants have been screened and 8 were confirmed through sweat tests to have the condition. All are currently receiving treatment.

Notes - 2007
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

The Joint Advisory Committee (JAC) for Newborn Screening (NBS) and Children with Special Health Needs (CSHN) recommended in FY06 that the 19 optional screening disorders become

part of the mandatory panel. Effective, January 2006, the panel included 28 disorders. During FY07 the JAC undertook a planning process for including cystic fibrosis screening for all newborns. The JAC recommended that it be added in July 2008. The Genetics Program coordinator worked with all stakeholders and interested parties to ensure systems were in place to ensure infants were receiving 100% follow-up in a timely manner.

Notes - 2006
The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)

Indicators prior to 2002 are not accurate for this measure due to a misunderstanding concerning how it should be calculated. The 2002 and 2003 indicators were updated in September 2005 to meet the definitions provided in the block grant guidance.

As of July 2001, Maine screens for 9 mandatory conditions (including hemoglobinopathies) and has an optional panel of 19 metabolic disorders.

a. Last Year's Accomplishments
The data for this measure come from Maine's Newborn Screening Program (NBSP). In 2007, 100% of newborns that screened positive for one of the conditions monitored by Maine's NBSP had timely follow-up to definitive diagnosis and clinical management. Maine has maintained this high standard since at least 2002 and preliminary data from 2008 indicate that we continue to provide timely follow-up to all positive screens.

Maine consistently screens over 99% of infants born in the state. During CY07 Maine screened 13,888 of the 13,975 births that occurred in the state (99.3% of newborns screened). Of these, 18 were identified with disorders. All affected infants were receiving appropriate consultation and treatment within 48 hours of confirmation. Maine's success can be attributed to our ability to link metabolic screening data with birth certificate data. In addition Maine has developed a close working relationship with our 2 specialty centers thus ensuring timely follow-up for infants. Maine has two major medical centers that have Genetic Programs and Cystic Fibrosis Clinics. The Maine Newborn Bloodspot Screening Program benefits from consultation with these specialists and with pediatric endocrinologists and hematologists.

The Joint Advisory Committee (JAC) for Newborn Screening and Children with Special Health Needs (CSHN) recommended that 4 additional disorders become part of the mandatory panel. Effective July 1, 2008 the panel included 32 disorders, including cystic fibrosis.

During FY07 a workgroup was convened to plan cystic fibrosis newborn screening to start July 1, 2008. The Genetics Program coordinator worked with all stakeholders and interested parties to ensure systems were in place to ensure infants were receiving 100% follow-up in a timely manner. The CF Workgroup included professional staff from both CF Clinics, Directors of CF accredited sweat labs, geneticists, genetic counselors, neonatologists, a practicing pediatrician, a parent and NBSP staff. The workgroup enhanced the service system to facilitate early identification, diagnosis and services for infants with CF. Materials were developed for primary care providers to assist in referring infants with a positive CF screen for further evaluation and treatment. Grand Rounds presentations were held in several birthing hospitals statewide as well as education with perinatal nurses. Teleconferencing increased the number of providers who participated. Additionally materials were mailed to all perinatal care providers and others who educate families about screening activities.

The JAC continues to be more family centered in its structure through parent participation on the committee. Parent members represent families with children who have PKU, Congenital Hypothyroidism, Fatty Acid Disorder and Cystic Fibrosis. The Committee is co-chaired by a health

care provider and a parent member. The co-chairs assist in directing Committee projects and preside over Committee meetings.

During FY06, the NBSP brochure was revised to meet the needs of expectant and new parents. Input from providers, parents and the advisory committee members was considered. The brochure provides an introduction to newborn screening and the importance of follow-up. Several models including one developed by HRSA were considered. The New England Regional Genetics Group (NERGG) subcommittee on education developed a regional brochure that was adapted for Maine. The brochure was translated into 14 languages and is now available on the Maine CSHN and Newborn Screening website at: http://www.maine.gov/dhhs/boh/cshn/bloodspot_screening/nbs_booklet.html as well as the NERGG website under the Resources and Links tab at: http://www.nergg.org. Healthcare providers and birthing hospitals were notified of the link so they could access the translated version. Translation was funded through the New England Regional Genetics Group and multiple copies were disseminated to each state to share with birthing hospitals. A newborn screening parent education packet was developed and distributed to birthing hospitals and primary care physicians in Maine during FY08. The packet includes a newborn screening poster and new brochures in several languages.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop program resources				X
2. Explore new approaches to providing screening education				X
3. Evaluate effectiveness and efficiency of CF screening system				X
4. Facilitate access to comprehensive genetic services statewide				X
5. Evaluate screening recommendations for NICU infants				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Preliminary data from CY08 indicate that 99.5% newborns were screened and 30 confirmed cases were identified. Of these 100% needed and received treatment in a timely manner. CF screening started in July 2008 and between July-December 2008, eight cases of CF were confirmed. The program only anticipated having 5 confirmed cases per year. The case rate of other conditions did not change.

One of Maine's clinical geneticists, Dr. Stephen Amato from Eastern Maine Medical Center (EMMC), relocated to Arizona in January 2009. EMMC negotiated an agreement with Maine Medical Center to provide for clinical and metabolic services in Bangor. Dr. Wendy Smith is providing clinic services 2 days each month and consulting with providers by phone and telemedicine. The Genetics Program is working with EMMC and MMC to facilitate planning to assure access to comprehensive genetic services in northern Maine.

During FY08 the NBSP initiated a review of several areas of QA/QI including the usefulness of our result report letters to providers. Several result letters and fact sheets are being revised to provide accurate and up to date information and guidance to the Primary Care Provider for evaluation and follow-up of abnormal screening results. Various guidelines for screening infants in the Neonatal Intensive Care Units are being reviewed and considered for implementation including the recently proposed protocols from the National Clinical Laboratory Standards

Institute.

c. Plan for the Coming Year
Maine has continued to set an objective of 100% for this measure and we will continue to communicate with Primary Care Providers and Specialists to maintain our current follow-up rate.

The NBSP will continue to collaborate with statewide CF Centers and examine the effectiveness of CF screening and the system of diagnosis and services; including CF screening education efforts; and refine fact sheets and education materials.

Refine protocols related to NICU babies. The National Clinical Laboratory Standards Institute has completed soliciting comments on draft protocols for infants in NICU. The final protocol will be released in the summer of 2009. The NBSP will review the final protocol and the protocol used by the New England Newborn Screening Program, consult with the two major medical centers and the Joint Advisory Committee, to determine if Maine will change its screening recommendations for NICU infants.

Explore the possibility of using web-based methods of providing education and outreach to providers, provide links to useful newborn screening information and conduct lunch and learn sessions.

We will explore approaches to long-term follow-up and outcome assessment as part of a comprehensive newborn screening system. Discussions will include the JAC, parents and other partners, including the New England Regional Genetics Collaborative. Data collection will begin in FY09.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	62.8	62.8	62.8	65	60.7
Annual Indicator	62.8	62.8	62.8	60.7	60.7
Numerator					
Denominator					
Data Source					NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60.7	60.7	65	65	65

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objectives for 2009 are based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Maine's value on this indicator is comparable to the national indicator of 57.4%. An objective of 65% is projected for the next administration of the survey. The objectives for 2007 and beyond were changed based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 62.8 % is the value for Maine from the the first National CSHCN Survey carried out in 2001. It is comparable to the national indicator of 57.5%. An objective of 65% is projected for 2007 when data become available from the second administration of the survey. The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

The indicators for 1998 to 2001 are NOT percentages. They reflect the average score (on a 0 to 18 point scale) of a family participation questionnaire. The method for determining the score changed in 2000 so that parents themselves answered the questionnaire. This represents a more accurate measure of parental involvement in the CSHN Program.

a. Last Year's Accomplishments
Maine's Children with Special Health Needs (CSHN) Program values the input it receives from the families it serves and works diligently to ensure families are involved in decisions regarding their child's health and services received from health care providers and the CSHN Program.

Data from the most recent National Survey of Children with Special Health Care Needs (NS-CSHCN) indicate that over 60% of Maine families partner in decision making and are satisfied with the services they receive. There was not a significant change in this measure between the

2001 and 2005/2006 Surveys and Maine is comparable to the national average on this indicator. Maine ranks 14th overall in the United States on this indicator.

In FY07 the CSHN Program used Report Cards to assess family satisfaction with supports and services. Results of the report cards were similar to results of data from NS-CSHCN. During FY08 the program went back to the regions to report findings to families. Overall most families agreed with the findings. The program also solicited input from families on their perception of issues in their region and priorities to be addressed. We heard that supports and services in navigating the system were a primary concern and families expressed a desire to have more opportunity to influence policy-making that impacts them. The regions were very appreciative of the feedback gleaned from the surveys and the effort on the part of the program to report findings back to them and seek input from families to inform program planning.

A major programmatic change in FY08 was the implementation of a move from direct to population-based and infrastructure services. The program worked with a Family Advisory Council (FAC) member who provided advise on sharing this change with families and its impact on them moving forward.

Families were actively involved in all aspects of the CSHN Program. Families are members of all CSHN sponsored advisory councils:

1. Joint Advisory Council for Newborn Screening and CSHN (JAC) -- Family members co-chaired the council.
2. Acquired Brain Injury Advisory Council (ABIAC) -- Family members and individuals participated on many sub-committees and continued to make recommendations to the BI Program within the Office of Adults with Physical and Cognitive Disability.
3. The Family Advisory Council and Youth Advisory Council to the CSHN were combined and met quarterly.
4. Newborn Hearing Advisory Committee -- Families co-chaired and actively participated in providing insight and guidance in policy development.

As diversity continues to increase in Maine it is important that the CSHN Program understand, develop and deliver services that are meaningful, accessible, and culturally appropriate to our changing consumer base. The CSHN Program worked with the National Center on Cultural Competence to conduct a needs assessment on cultural and linguistic competence. Through this process we focused first on our program to determine if CSHN Program and staff could communicate effectively, and convey information in a manner that is easily understood by diverse audiences including individuals with disabilities. For the CSHN Program to respond effectively to the health literacy needs of the population it serves we determined that policies, structures, practices, and procedures must be in place to support this capacity. The CSHN Program also engaged Family-to-Family regional coordinators in cultural competency training at monthly meetings in an effort to report progress back to the regions. The CSHN Program continues, through staff member Diane Haberman, to engage staff on a monthly basis to discuss various topics on cultural and linguistic competence.

The Maine CDC contracted with the Maine Center for Public Health to evaluate the Maine Newborn Hearing Screening Program (MNHP). The 30-question survey was developed in partnership with MNHP staff as well as a review of other state's parent surveys (i.e., Massachusetts, Wisconsin). The survey was designed to measure feedback from all parents, regardless of hearing test results. Thus, using skip-logic, only parents who had babies who were referred were asked to answer specific questions regarding their referral and/or hearing loss. Survey results revealed a need for increased education and involvement of parents in the NH process, and work on QI with hospitals. Complete survey results can be found at: http://www.maine.gov/dhhs/boh/cshn/documents/pdf/Parent%20Feedback%20Survey.pdf

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to recognize families as partners through the Family Advisory Council Joint Advisory Council, Acquired Brain Injury Advisory Council and Newborn Hearing Screening Council		X	X	X
2. Continue to have parents complete Form 13 and expand to family members on other councils		X	X	X
3. Continue contract with a family and youth consultant as appropriate		X	X	X
4. Continue active family participation on all MCH boards and councils		X	X	X
5. Engage families in cultural competency training through regional FACs		X	X	X
6. Engage youth and families in the regions to participate in the MCH 2010 Needs Assessment		X	X	X
7. Work with the Office of Public Health Emergency Preparedness (OPHEP) to identify the CSHN Program role in emergency preparedness for families with children with disabilities				X
8.				
9.				
10.				

b. Current Activities

Although there was no change in this measure over the past four years, data from Maine's parent report card for 2006 suggest that families would like to play a more active role in policy making.

The Program is working with its evaluator to follow up with parents to determine how they are adapting to the change from direct services. The program has helped facilitate obtaining other payment options such as MaineCare and we want to learn more about how families are coping with finding resources and making additional out of pocket payments for services.

We are also working with Dr. Richard Aronson on developing diversity training for the Youth Advisory Council. The training will enhance cultural and linguistic competence as a component of leadership development for youth with special health needs. This is a three part series with two objectives: 1) enable youth to strengthen their capacity to understand and respect themselves and each other-honoring their diversity and, at the same time, discovering and acting upon their shared humanity; and 2) start to understand the definition and essential elements of cultural and linguistic competence.

The program is developing a brochure that describes its re-structure to care-coordination and what that means for families. We anticipate being able to market to families by Summer 2009.

c. Plan for the Coming Year

Maine's objective for this measure in future years is 65.0%. We believe this is an obtainable objective given our efforts in this area, our shift towards infrastructure building, and the use of the regional report card grades allows us to actively involve families and youth at various levels. Given that we plan to engage the regions with the results we anticipate that families and youth will work with the Family-to-Family Health Information Center partners to create systems that ensure children, youth and family needs are met.

During FY10 the CSHN Program will focus on fully developing and provide leadership training for

the 6 regional Family Advisory Councils (FAC) and Youth Advisory Councils (YAC). Our family consultant, Anna Cyr, will conduct the trainings.

We will work with the new public health districts and Family-to-Family regions to ensure people with special health needs have a voice at the local level. Through improved communication with the Healthy Maine Partnerships and Comprehensive Community Health Coalitions we hope to create awareness of children with special health needs.

The 6 Regional Family-to-Family Health Information Centers and Resource Coordinators will participate in quarterly cultural competency awareness trainings under the guidance of Dr. Richard Aronson. The CSHN Program will continue to work with Dr. Aronson on the National Center for Cultural Competence, cultural competency training for youth and families.

The JAC, Newborn Hearing Screening Council, ABIAC and FAC will continue to provide advice and recommendations to the CSHN Program and the Office on Brain Injury on policy and development.

Conduct focus groups with families and youth to inform the 5-year needs assessment.

Explore the feasibility of addressing the issue of emergency preparedness for families with children with disabilities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	60	60	65	51.7
Annual Indicator	60	60	60	51.7	51.7
Numerator					
Denominator					
Data Source					NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	51.7	51.7	55	55	55

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Given the changes in this indicator between the two CSHCN Surveys, we have adjusted our objective for future years to 55%.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2005 indicator of 60% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 52.6 %. An objective of 65% is projected for 2007 when data from the next administration of the survey become available. The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

The percentages for 1998 to 2001 refer to the original NPM # 3. For 1998 the numerator and denominator were based on estimates from the 1992 National Health Information Survey (NHIS), adjusted for Maine. From 1999-2001, the CSHN Program used an 18% prevalence rate based on the work of Paul Newacheck.

a. Last Year's Accomplishments
Data from the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) for Maine indicate that about half of parents (51.7%) with a CSHN received coordinated, ongoing, comprehensive care within a medical home. Due to changes in the 2005-06 NS-CSHCN, we cannot compare the results from the 2005-2006 Survey with the 2001 NS-CSHCN. Maine's percentage on this indicator is higher than the national average of 47.1% and Maine ranks 13th overall in the U.S. on this measure.

A report based on data from the NS-CSHCN for Maine was completed in Spring 2008. Results of this report revealed there was wide variation in this measure based on the classification of a child's special health need. For example, the % of CSHN who had a medical home was significantly higher for CSHN whose conditions were managed by prescription medications only (61.3%) than children whose conditions resulted in functional limitations (39.0%). Overall, parents of Maine CSHN reported positive experiences with their health care providers, though again there were some differences by type of special health need.

In FY07 the CSHN Program used Report Cards to assess family satisfaction with this measure. During FY08 the program went back to the regions to report findings to families. Overall most families agreed with the findings. The program also solicited input from families on their perception of issues in their region and priorities to be addressed. The regions were very appreciative of the feedback gleaned from the surveys and the effort on the part of the program to report findings back and seek input from them to inform program planning.

The Hood Center at Dartmouth University was awarded a HRSA grant to "Improve Access to Care for Children and Youth with Epilepsy". The project is using a learning collaborative structure to increase the effectiveness and quality of care received in a medical home in four key practices in New Hampshire and Maine with diffusion to other providers through education and community outreach. The Maine CSHN Project worked with Kennebec Pediatrics and Southern Maine

Neurology to improve care coordination between the practice and specialists working with families to de-stigmatize epilepsy for youth and families. Families were involved in the selection of the action plan and medication list for epilepsy and what parents needed once they left the primary care practice office. Staff focus on a programmatic change from direct to population-based and infrastructure services during FY08 prevented expansion of the project to additional practices.

One component of the CSHN and Genetics Programs merger in 2006 was movement of the MaineCare Member Services Early Periodic Screening Diagnosis and Treatment (EPSDT) from the Infectious Disease Division's Immunization Program to the Family Health Division in November 2007. MaineCare Member Services is responsible for assuring that MaineCare members under the age of 21 who receive full MaineCare benefits are informed of and receive the services and assistance available to them under the MaineCare Program. As a result of MaineCare Member Services relationship with Title V, the Title V program now plays a more active role in ensuring that children receive ongoing, coordinated access to medical care. The CSHN Program and MaineCare Member Services are in the process of instituting a health care coordination component that provides resource information to family community-based services. ChildLINK will be the method used to track encounters.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the Epilepsy Learning Collaborative	X	X	X	X
2. Continue collaboration and partnership with the Maine Chapter of the AAP			X	X
3. Participate at the Maine Chapter of AAP Annual Meeting				X
4. Work with 4 Patient Centered Medical Home Pediatric sites to ensure comprehensive, coordinated and family-centered values exist for all children including CSHN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY09 activities for the National Initiative for Children's Healthcare Quality Learning Collaborative on Epilepsy are focused on enhancing the capacity of primary care providers and pediatric neurologists to co-manage the care of children and youth with seizure disorder. This will be accomplished by creating a more effective system of co-management of seizures between pediatricians and pediatric neurologists by increasing awareness and understanding of seizure disorder and the related challenges faced by those with epilepsy. During Year 1 Kennebec Pediatrics in Augusta will partner with Maine Neurology in Portland to work effectively with approximately 20 children and youth with seizure disorder. During Year 2 Husson Pediatrics in Bangor will partner with Neurology Associates of Eastern Maine to work effectively with approximately 25 children and youth with seizure disorder. The first phase in both practices is identification, development of a seizure action plan and medication list that will be made available to families.

c. Plan for the Coming Year

Maine is working to ensure that all children have a medical home and we hope to see improvement in this measure in the coming years. Due to changes in wording of this indicator between the 2001 and the 2005 National Survey's for CSHCN we have changed our objective for this measure to make it more realistic. We recognize there is a disparity between those children managed by prescription medications only and functional limitations, our overall goal is to have at least 55% of parents reporting that their child is receiving care through a medical home by the release of data from the next NS-CSHCN, which we anticipate will occur in approximately four years.

A major strategie recommended in the biennium State Health Plan released in April 2008 to enhance the development of integrated care models was to design and implement a Patient Centered Medical Home pilot. The MCH Medical Director was a member of the committee that selected 4 pilot sites. (Described under Other Program Activities) The CSHN Program will support the work of the Task Force to encourage engaging more children.

Explore the feasibility of using the Massachusetts model to fund coordinators in medical home practices when they transitioned from direct services to determine if it can be replicated in Maine.

Explore the feasibility of sending e-alerts via AAP pediatric listserv to pediatricians on issues related to CSHN.

Other activities include:

Re-structure web site to include sections specific to providers, families and other interested parties. The site will include resources and links resulting in a user-friendlier site.

Continue to collaborate and enhance our relationship with the Maine Chapter of AAP through increased awareness of medical home and partners in chronic care.

Continue collaboration with the Hood Center at Dartmouth University on the Epilepsy Project.

Remain informed of activities of the patient-centered Medical Home Learning Collaborative. (The focus of this collaborative is adults with chronic illness)

Work with EPSDT to determine scope of services provided and how the CSHN Program can enhance care coordination by providing additional resources or brokering connections with Family-to-Family Health Information Centers.

Initiate conversations with liaisons for the newly formed public health districts to provide information on the medical home. Information would consist of a definition of a medical home and what it would mean if the term were used in communities.

Develop a brochure for families on the medical home that includes what it is and what to expect from a medical home. The brochure will be disseminated with other informational materials by EPSDT to families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	67.3	67.3	67.3	70	70

Annual Indicator	67.3	67.3	67.3	70	70
Numerator					
Denominator					
Data Source					NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we don't anticipate improvements in this measure over the next several years. We hope to maintain the current level.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN Survey.

Due to the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we don't anticipate improvements in this measure over the next several years. We hope to maintain the current level.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 67.3% is the value for Maine from the first National CSHCN Survey in 2001. This is higher than the national measure of 59.6 %.

An objective of 70% is projected for 2007 when data from the next administration of the survey become available. The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

a. Last Year's Accomplishments
According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 70% of families with CSHN in Maine reported that they had adequate private and/or public insurance to pay for services they needed. This is slightly (although not statistically significantly) higher than the 2001 Survey (67.3%). In both survey years, Maine's rate was

significantly higher than the national average. In 2005-2006, Maine ranked 2nd overall in the U.S. on this measure. 97% of Maine CSHN had some form of health insurance at the time of the 2005/06 Survey. Half (51%) of CSHN had private health insurance coverage only. Thirty-Three percent had public insurance only and 13% had a combination of public and private insurance.

In FY07 the CSHN Program used Report Cards to assess family satisfaction with this measure. During FY08 the program went back to the regions to report findings to families and solicit feedback on family issues. We heard from families that they were experiencing payment issues, both MaineCare and private insurance for such things as durable medical equipment, wheel chair adaptation and hearing aids; frequently having to pay out of pocket for these services.

In an effort to remain within budget, in July 2005, the CSHN Program ceased enrolling children receiving MaineCare into the medical services payment component of the CSHN Program with the exception of those with inborn errors of metabolism and cleft lip and/or palate. Beginning July 2006 families were required to submit their most recent IRS 1040 as verification of income, further reducing the number of children eligible for CSHN Program services. In the past the program accepted self-declaration, these two steps reduced overall direct care numbers by 50%. During CY08 direct services were provided to 260 infants, children and youth; 29 were less than one year old. The Program's major expenses continue to be (50%) medications and medical supplies.

During FY08 the Program continued to administer the Southern Maine Cleft Lip and Palate Clinic and 4 Developmental Evaluations Clinics (DEC). Financial support to the DEC clinics ended December 31, 2008. One clinic closed and the remaining three hospital-based clinics are evaluating their ability to continue. The statewide DEC's saw approximately 509 children during FY08.

As discussed under PM # 2 the program moved from providing direct to population-based and infrastructure services in FY08. To assist staff in making determinations around service provision during the transition period, the direct services staff developed a ranking system from one to three. A rank of 1 -- children may be on medications with an annual visit to a specialist and have health insurance therefore cost to the family is minimal. Those children will be removed from the program as they come up for re-enrollment. A rank of 2 -- children may have multiple medications and multiple physician visits and may or may not have health insurance. The program schedules a meeting with the family prior to removing from the program. A rank of 3 -- children are highly involved, parents may or may not have health insurance, and their ability to pay co-payments and deductibles presents a financial burden making it very difficult for the program to drop the family.

In a report compiled in Spring 2008 using data from NS-CSHCN for Maine, we found that more families with CSHN were insured through public insurance in 2005-2006 compared to 2001. Given the current economic climate and proposed budget cuts to MaineCare in the state, we are unsure how this could affect the health insurance status of CSHN in Maine. Also, new MaineCare policies that now require documentation of citizenship and identity are causing many families in Maine to not re-enroll in MaineCare. Costs associated with obtaining birth certificate copies, particularly if from another state, if families have misplaced or lost them is a deterrent. Outreach efforts are currently underway to locate these families and encourage them to re-enroll.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to build on the existing relationship with the Office of MaineCare Services		X	X	X
2. Monitor changes in benefit plans both public and private		X	X	
3. Work with the National Catalyst Center to improve health care		X		X

insurance and financing for children and youth with special health needs				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
On April 17, 2009 the CSHN Director participated with the National Catalyst Center on Insurance Issues for CSHN. Discussions centered around ways Title V Programs could promote improved healthcare financing (reimbursement) for children with special health needs.

The CSHN Program is also working with the Catalyst Center on mechanisms to provide information to families on the Family Opportunity Act, a federal law that provides a new optional eligibility category to allow states to offer a Medicaid buy-in for disabled children who would be eligible for SSI disability but for their income, who are in families up to 300% of poverty. The bill also provides funds for establishing health information centers to assist and support families of children with disabilities and special health needs.

c. Plan for the Coming Year
Maine's objective for this measure for the next four years is 70%. In other words, we do not anticipate improvement on this measure in the next few years. Given the current economic climate and proposed cuts to services such as targeted case management and rehabilitation, we will be successful if we maintain our current level. We will monitor changes in benefit plans both public and private for any potential impact on CSHN.

We will continue to monitor activities related to insurance changes at the federal level and how those changes may impact services of both MaineCare and other insurances; provide input as appropriate on MaineCare service changes, and work with MaineCare to discuss services and assist families as needed.

As we move from providing direct services we will assist families in navigating through barriers to enrollment and re-enrollment in MaineCare and link to necessary resources. We will work with families on seeking alternative methods for payment of services.

As the program moves away from providing direct services, review potential for funding gaps in services for those families most in need by developing criteria for qualification to receive funds.

Implement expanded SCHIP regulations.

The CSHN Program website will make available data on children with special healthcare needs to include but not limited to SLAITS, National Survey of Children with Special Health Care Needs, Newborn Hearing Bloodspot Screening, and Birth Defects statistics; providing our stakeholders with information on the CSHN population.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	77.3	77.3	77.3	79	87.9
Annual Indicator	77.3	77.3	77.3	87.6	87.6
Numerator					
Denominator					
Data Source					NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87.9	87.9	90	90	90

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN Survey. The data for the two surveys are not comparable for PM #05.

Due to changes in this indicator between the two CSHCN surveys, we have changed our objective to 90%.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The 2006 indicator of 77.3% is the value for Maine from the first National CSHCN Survey in 2001.This is comparable to the 74.3 % for the nation as a whole. An objective of 79% is projected for 2007 when the data from the next administration of SLAITS will be available.

The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

This was a new measure in 2002; no data are available prior to 2002

a. Last Year's Accomplishments

Approximately 88% of families with a CSHN in Maine report that community-based service systems are organized so they can use them easily according to the 2005-2006 NS-CSHCN. Due to changes in the wording and placement of the questions between the 2001 and 2005-2006 NS-CSHCN, we cannot make any statements about changes with this measure. Maine's performance on this measure is slightly lower, but comparable to the national average of 89.1%. Maine ranks within the bottom third of states on this measure.

In a report completed in Spring 2008, we examined how this measure varied by type of special health need. Parents of CSHN with functional limitations were significantly less likely to report that services were organized in ways they could easily use them. While 96% of parents with CSHN managed by prescription medications reported ease in using community-based services, only 73% of parents with CSHN whose condition results in functional limitations reported ease in using community based services. This is important information for Maine's CSHN Program, which primarily works with children with functional limitations.

During FY08 the CSHN Program reported back to the regions results of FY07 Report cards submitted by families for this measure. The program also continued discussions on issues of concern in each region and potential solutions. Issues were primarily around access to services, either a lack of services in a particular area or lack of knowledge that a services was available; concern around school perception of this measure being an education model rather than a medical model resulting in an unwillingness to pay for durable medical equipment or therapy for a child that might not be related to the educational component. Families continued to be dismayed by the "systems" that appear to be fractured and non-communicative with each other. Families continued to consider themselves as the primary case manager responsible for locating services for their child.

To address these issues the CSHN Program continued to partner with Maine Parent Federation/Family Voices Regional Family-to-Family (F2F) Health Information Centers. CSHN staff held several meetings with the 6 Regional F2F Health Information Coordinators to coordinate and support regional Family Advisory Council efforts. The regional coordinators are responsible for educating, informing and serving as advocates to families in need. The coordinators assisted the program in forming the 6 Family Advisory Councils. Each council is representative of their region; the area of focus and the composition is dependent on the needs of a particular region. Each council has, as a member, the Family-to-Family Health Information Resource Coordinator who assists the CSHN Family Consultant in arranging gatherings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate activities among MCHB funded initiatives				X
2. Support 28th Annual Special Family Weekend				X
3. Support the 6 regional FAC Coordinators				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHN Program Direct Services Team has been developing an action plan to transition from direct services to a community-based system of services. Discussions centered on what this

means for staff and families and what the new system will look like. Prior to this change there were about 500 children participating in the medical services payment aspect of the program. As discussed under PM # 4 we are using a ranking system to move families off the program, while at the same time expand our role to support families of CSHN by locating other state systems, community-based systems and other agencies to assist with payment of such items as durable medical equipment. The program is expanding its role in linking families with, rather than providing services. Criteria are being developed to identify potential services that may be paid by the program if not available from another source.

The Service Tapestry database (a user-friendly, searchable database of resources for youth, family members, educators and service providers to locate supports and services within their area) consisting of information and resources for children ages birth - 25 years is operational and can be found at: http://www.servicesforme.org/. Servicesforme was developed under the HRSA Integrated Services Initiative allowing the program to move the Service Tapestry from the University of Maine to a temporary site at the Maine Support Network until the state develops protocols to accommodate searchable websites.

c. Plan for the Coming Year

Currently, Maine families with CSHN report that 87.9% of community services are organized and easy for them to use. We hope, that through our efforts, this value will increase over time and reach 90% by 2011 when the next survey results are available.

The CSHN Program will form six Regional Family and Youth Advisory Councils to be located in the six F2F Health Information Regions. Representatives from each council will form a larger statewide Family and Youth Council. The regional councils will be responsible for assessing community needs via Report Cards reporting back to the region and with assistance from the CSHN Program enhance and improve systems currently in place.

Maine has an emerging public health infrastructure comprised of 8 regional public health districts. The new infrastructure has the potential of enhancing the existing 6 Regional F2F Health Information Centers in several areas: 1) strengthen efforts to enhance the delivery of the 10 essential public health services specific to CSHN families; 2) develop local and regional health improvement plans; and 3) assure accountability for use of state resources. The CSHN Program will establish a relationship with new Public Health District Liaisons to share resources on community-based resources for CSHN families.

Continue to enhance coordination among Maine's MCHB funded grants to optimize funds and resources.
Complete action plan for transitioning from direct to community-based service provision that will serve all children with special health needs including those with autism and other cognitive disabilities.

Continue to fund both the Youth and Family Consultant positions to optimize the delivery of services in the six Family-to-Family Health Information Centers in Maine. This will be accomplished by building the infrastructure to support 6 regional family and youth advisory councils through enhanced leadership development. Youth leadership development will be based on the National Consortium on Leadership and Disability for Youth and Family Leadership on trainings developed by the University of Vermont and the Parent Advocacy Coalition for Educational Rights (PACER) Center. The mission of the PACER Center is to "expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents". Continued work in this area will allow us to assess services and be responsive to anticipated needs.

Conduct on-going needs assessment by mapping one region per year to identify unmet CSHN

needs.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	14.9	14.9	14.9	16	49
Annual Indicator	14.9	14.9	14.9	49	49
Numerator					
Denominator					
Data Source					NSCSHCN 2005/2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	49	49	51	51	51

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN Survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN Survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Due to substantial changes to this measure between the 2001 and 2005/2006 CSHCN Surveys, we have changed our objective for 2011 (when we anticipate that the next data will be available) to 51%.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

The indicator of 14.9% is the value for Maine from the first National CSHCN Survey in 2001. This is comparable to the national indicator of 5.8%. Maine is the only state in the county with sufficient sample size to reliably report on this measure.

An objective of 16% is projected for 2007 when the survey data from the next administration of SLAITS is available. The objectives for 2007 and beyond were changed this year based in part on a "report card" administered by the Maine Children with Special Health Needs Program to about 40 stakeholders across Maine. These CSHN “Report Cards” are based on the work done by Utah State University, Early Intervention Research Institute’s Measuring and Monitoring Community-based System’s of Care for CYSHCN. The ”report card” is a CQI process that has provided the Maine CSHN Program essential information on the degree to which the program’s services, policies and practices are working for families.

This was a new measure in 2002; no data are available before 2002.

a. Last Year's Accomplishments
Maine is at the forefront of helping youth with special health needs transition to adulthood. About half (49%) of Maine families with a CSHN age 12-17 report their children have received services to make this transition according to data from the 2005-2006 NS-CSHCN. Due to substantial changes to the set of questions that constitute this measure, we cannot compare the 2001 and 2005-2006 NS-CSHCN results. However, Maine's percentage on this measure exceeds the national average of 41.2% and Maine ranks 9th in the U.S. on this measure.

Through the Integrated Services Grant the Youth Coordinator, Mallory Cyr, worked with youth and youth groups to bring them together on various issues impacting young adults with disabilities. She initiated a chat room for youth to share and discuss common issues; directed five regional youth advisory coordinators; spoke with youth in 3 of the Family Health Regions about being part of a larger statewide youth advisory council.

Through the Healthy and Ready to Work (HRTW) and Integration Grants we collaborated with families and youth to address youth leadership and build a strong interagency partnership with the Department of Education (DOE) to address issues of higher education and employment. The Maine Support Network contracts with the DOE to provide workshops to school departments and added a session on transition to address Healthy and Ready to Work (HRTW). While the CSHN Program is not a partner with, it does support the efforts of Project THRIVE. The Maine Parent Federation and the statewide Maine chapter of Family Voices is working with the Maine DHHS Division of Children's Behavioral Health, Tri-County Mental Health Services and the Substance Abuse and Mental Health Services Administration on this initiative. THRIVE principles include building a seamless system of care for children and their families. It is a new way of working as a community to offer services that are family driven, youth guided, and culturally and linguistically competent, while creating systems and services that are trauma informed.

In FY08, the CSHN Program invited HRTW National Resource Center youth and family experts for a discussion about transition from a youth and family perspective. The discussion was focused on emerging issues relevant to the CSHN Program shift from direct services to a greater focus on community-based systems of care.

The HRTW youth coordinator reviewed youth materials for the National Center to ensure they were youth appropriate and contained language used by today's youth. She presented on transitioning to adult health, from her perspective, at the National Initiative for Children's Healthcare Quality conference in March 2008.

The youth coordinator developed a web-based self-determination program for young adults to learn how to self-advocate in various settings such as; employment, health care, and navigating a college campus.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gather, through report cards, regional youth issues and use results to design educational opportunities to enhance knowledge on transition		X		X
2. Maintain partnership with young adults (THRIVE) who are either homeless or have other cognitive issues		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We are working with the youth coordinator to administer a youth self-assessment to determine where they feel they are in their growth as a leader. Based on assessment results we will discuss what supports they feel are needed to grow in the areas identified and design a leadership training course based on a national model of what youth feel they need to become leaders in Maine.

The CSHN Program formed a workgroup comprised of Maine Parent Federation, Maine Transition Network, THRIVE, and the youth coordinator to look at youth activities taking place across the state. Based on the workgroup's findings recommendations will be made to combine activities where appropriate.

c. Plan for the Coming Year

Due to substantial changes to this measure between the 2001 and 2005-2006 Surveys, we have changed our objective on this measure to 51%.

In collaboration with the Maine Support Network we plan to establish at least four YACs in the regions. The youth coordinator will explore the feasibility of using facebook as a mechanism to convene the YAC's rather than the traditional face to face quarterly or semi-annual meeting format. This format is a widely used communication tool by youth and they may be more willing to discuss youth issues via this medium rather than in person. The youth coordinator has created a facebook page but it is currently in a ‘get acquainted' format with plans to initiate conversations on various topics.

We will work with Maine Chapter of AAP and Dr. Lisa Letourneau to establish a medical home track for pediatricians to ensure transition from pediatric to adult health care and what that means; and continue to work with practices involved with Partners in Chronic Care model of care coordination to integrate transition into the practice.

The CSHN Program will review MaineCare member materials on transition and offer suggestions for changes that can be included with the MaineCare letter sent to children prior to their 18th birthday informing them they will no longer be covered.

Continue identifying and inviting youth to be part of a regional or statewide YAC, as well as,

include in the statewide needs assessment.

Conduct needs assessments in particular regions of the state for youth with special health needs to monitor progress. For example we may have the youth coordinator pose a question of facebook monthly or bi-monthly and see how youth respond.

Through the State Implementation Grant we will offer transition workshops for Special Education Directors.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	72	80	82.5	84	85
Annual Indicator	82.1	83.3	79.8	77.6	77.6
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	81	82	83	84

Notes - 2008
Data are from the 2007 National Immunization Survey. 2008 survey data are not yet available; 2007 data are used as an estimate.

Notes - 2007
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 2007 is based on the National Immunization Survey 4:3:1:3:3 series.

Notes - 2006
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Reporting for 2006 is based on the National Immunization Survey 4:3:1:3:3 series. (Note: The 2002 and 2003 indicators were corrected for the FY06 block grant application; the values reported in prior applications were incorrect.)

a. Last Year's Accomplishments
Maine's childhood immunization data are obtained from the National Immunization Survey (NIS), a continuing nationwide sample survey conducted among families with children 19-35 months of age and their healthcare providers.

According to NIS data, Maine's immunization rates among 19-35 month olds, based on the 4:3:1:3:3 series, have not changed significantly over time. However, Maine's 2007 immunization rate was the lowest it has been in recent years. In 2007, 77.6% of children received the full 4:3:1:3:3 schedule. Only 11 states in the U.S. had lower 2007 immunization rates. Ten years ago in 1997, Maine's 4:3:1:3:3 immunization rate of 78.4% was the second highest in the country. Therefore, although Maine's immunization rates have not declined significantly over time, other states have been able to improve their rates. The Maine's Immunization Program (MIP) hypothesizes that this may be due to several factors. Between 1999 and 2003 a significant portion of program resources were focused on developing the ImmPact Immunization Registry with less available for provider education. In addition, the MIP centralized its staff from contracts on the county level to staff centrally located in the capitol (Augusta). This resulted in some communities without readily available educational resources. The MIP also experienced decreased staffing levels through resignations and delays in filling health educator, data registry manager and vaccine coordinator vacancies due to a state hiring freeze. Federal funding decreases resulted in the state's inability to match the Advisory Committee on Immunization Practices recommendations for Maine to be a universal vaccine state. This resulted in a decision to be a Vaccine For Children only state covering uninsured, underinsured children, Medicaid children, and American Indian children.

To gain a better understanding of the immunization decline the MIP partnered with the USM Muskie School in the fall of 2006 to develop and implement a survey with Maine parents of preschool children to identify both barriers to and incentives for getting children immunized. The state Title V Program provided the majority of the funding for the study. Of the 8,526 randomly selected mothers of children born in Maine between 2002 and 2006, 31.1% responded. The survey revealed that on average those whose children were not all immunized had more children under age 5 in their households and reported a higher level of completed education. While those reporting that not all children were immunized or all their children were immunized agreed with statements about the health protection of childhood immunization, the value of physicians' recommendations about vaccination, and the risk of childhood diseases, levels of agreement were lower among those whose children were not immunized. The most often cited reasons for not immunizing pre-school children were the number of shots administered at one time and concerns about autism. Many parents are also concerned that live vaccines may harm their child.

96.5% of enrolled children in home visiting during FY08 were up to date on immunizations, 97 % were 18 months and older. Immunization is embedded in the curriculum of home visitors and continues to be a performance measure for the contracted community agencies. As they become aware of the barriers families encounter (i.e. transportation) and assist with working through them, the home visitors record this data and share it with the MIP.

Maine's Home Visiting Program (HV) partnered with MIP to develop core messages for public service announcements. This was an informational activity in an effort to raise immunization rates. Materials were included in the home visiting "Welcome Baby Bags" that promoted immunization. Home visitors talk with parents about their specific concerns and risks and encourage them to talk with their doctor about immunization.

Since Well Child Clinics were discontinued and the creation of the Home Visiting Program, Public Health Nursing (PHN) contact with families is less. PHN sees only those with an identified health need and generally for a short period of time. For those seen, immunization history is part of intake and evidence-based information is given following the Bright Futures Standards.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and guidance regarding best practice and quality assurance/improvement				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The most recent data for this measure suggest that about 77.6% of children age 19-35 months in Maine received the full 4:3:1:3:3 immunization schedule in 2007. This is not as high as the state would like it to be and Maine's Immunization Program has been working to improve this rate.

In addition to MIP, other programs in the state are working to increase children's immunization rate. HV found that 96.5% of children enrolled are up to date on their vaccines. The MIP is working with HV to access their data to provide the program with more in-depth information on vaccines and the barriers faced by families trying to get their children immunized.

Maine families who are enrolled in HV have significantly higher rates of being age appropriately immunized. The very close relationship that families have with HV provides a unique opportunity to refer to health professionals or provide support around the need to immunize children.

The Maine CDC requested funds for vaccination in the biennial budget in an effort to purchase pediatric vaccines. Approval would allow the state to return to a universal state. The Maine Chapter of AAP is very vested in immunization and is a strong supporter of the state funding immunization.

c. Plan for the Coming Year

Maine's Title V program will continue to work with the MIP to learn about barriers to childhood immunization through the ImmPACT2 system and through our HVP. We will also investigate whether other data sources, such as MaineCare offer additional data that would be helpful in identifying geographic or demographic groups that could be the focus of intervention efforts.

While Public Health Nursing (PHN) collects immunization data it is contained in a medical record protected by HIPAA. PHN anticipates adding a SQL server that will allow the program to run public health data reports thus they can begin generating reports on immunization rates of children served. Community Health Nursing (CHN) will assess the feasibility of making changes to their database to collect immunization data on the children served.

PHN and CHN work with families referred to the program for an identified health need. Referrals are for a limited time, often within one to two months, which is prior to the first immunizations. While under their care, PHN/CHN check on the immunization status of those served, provide families with schedules and provide immunization education during visits. At the point of discharge PHN/CHN continue to refer those families still requiring support to HV thus ensuring additional follow up to obtain, in a timely manner, all appropriate immunizations for their children.

MIP will continue to work with the Early Childhood Director, Early Childhood Comprehensive Systems Initiative, and HVP to identify ways to link their respective databases and share data in an effort to provide a more complete picture of immunization of Maine residents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	12.6	12.3	10.4	9.6	9
Annual Indicator	10.5	10.7	9.9	9.4	10.3
Numerator	284	292	271	251	268
Denominator	27155	27257	27291	26825	26003
Data Source					Birth certificates, Maine Vital Records Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	9.8	9.6	9.4	9.2

Notes - 2008
2008 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. 2008 population estimates are from the US Bureau of the Census as of July 1, 2008.

Notes - 2007
2007 birth rate per 1,000 female population 15-17 is provisional and subject to revision. Birth data are from the Maine Office of Data, Research and Vital Statistics. 2007 population estimate from US Census Bureau as of July 1, 2007.

Notes - 2006
2006 birth rate per 1,000 female population 15-17 is provisional and subject to revision. 2006 population estimate from Maine Office of Data, Research and Vital Statistics.

a. Last Year's Accomplishments
Maine's adolescent pregnancy rate has been declining since 1998 and has consistently been lower than the U.S. rate. Based on data from 2007, Maine's rate of teen births was 8.8 per 1,000 females ages 15-17 compared to 22.0 per 1,000 in the United States. Maine ranks # 3 in the nation on this measure. For teen pregnancies in this age group, Maine met its 2010 goal in 2006 of 13.6 per 1000 females. However, it is important to note that Maine ranked # 7 in 2006 for births to adolescents age 15-19 years old; among 18-19 year olds, Maine ranks 11th in the country. Therefore, although Maine is doing well preventing pregnancy among younger adolescents, we need to be aware of trends among 18-19 year old adolescents.

2007 Maine Youth Risk Behavior Survey (YRBS) data reveal the % of teens who have had sexual intercourse has not changed substantially over the past few years (55.4% in 2007), but the % who report using a condom at last intercourse has increased since 1995 from 46.9% to 58.9% in 2007 and oral contraceptive use remains high at 41%, revealing the importance of family planning to lowering Maine's teen birth rates.

Maine is committed to keeping our teen birth rate low through its work with Family Planning clinics, ongoing data monitoring, and with educational programming.

Family Planning clinics served 29,530 clients including 8,099 teens in FY08 a decrease of 4.9% from FY07. According to Maine census data, the decrease is associated with a decline in the teen population in Maine and according to YRBS data, teen delays in sexual activity. In addition, family planning clinics have been essentially flat funded while costs have been increasing. During FY08, the cost of the oral contraceptive, Ortho increased significantly in price due to a change in federal rules. Maine's Medicaid agency, MaineCare, is working on covering Implanon, a 3-year implantable contraceptive. It can't be offered to Family Planning clients until it is covered by MaineCare. This is anticipated to occur in Summer 2009.

Full reproductive health services continue to be offered at 7 school-based health centers (SBHC).

In FY08 Family Life Education Consultants provided curriculum consultation, teacher training, and technical support to 30 priority schools and consulted with an additional 50 schools, serving a total of 411 educators. Activities included increased parent programs, serving 660 participants.

The Annual Comprehensive Sexuality Education Conference titled "Sexually Healthy: The Way Maine Should Be" was held April 9, 2008. The conference is intended for school administrators and health educators to increase school leadership support for comprehensive family life education, as well as to increase and update participant knowledge and skills in sexuality education. 147 participated in the conference. This is a continuation of a collaborative effort between TYAHP, Family Planning Association, and the Maine HIV/STD Program.

The Maine Department of Education held its annual Comprehensive School Health Education Spring Workshop in May 2008. 130 elementary and middle school teachers, high school health education teachers, administrators and school health coordinators attended. Teen pregnancy round table sessions included such topics as the Health Education Resource Collection and Elementary Foundations for Sexual Health.

During fall 2007 Maine's SBHCs came under pressure when a City of Portland middle school committee voted to allow the City's Public Health Division to provide prescription birth control to middle school students enrolled in the SBHC making it the first middle school in Maine to make prescription birth control available to 6, 7 and 8 grade girls. Despite much adverse media attention the school committee resisted pressure to reverse their decision or to set limits on providing prescription birth control to children younger than 15. In January 2008, the middle school began providing this service. As part of the policy change the SBHC revised its parent information and enrollment form and asked parents to re-submit forms mid-year. Only 2 parents chose not to re-enroll their children at the health center and overall enrollment has increased. Between January 2008 and June 2008, 1 student requested and received a prescription for birth control.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Family Planning Clinical Services	X			X
2. Community-based pregnancy prevention and family planning outreach		X	X	X
3. Comprehensive Family Life Education consultation			X	X
4. SBHC base funding, technical assistance and standards implementation				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In Spring 2009, Maine began administering an Integrated Youth Health Survey. Through this effort, all school-based surveys will be combined and any school will be eligible to participate. Questions on adolescent sexual health and behaviors will be included in the survey and data on some of these questions will be available at the local level. This will allow Maine's TYAHP to better focus its intervention efforts at the community level.
During FY08 a contractor was selected to administer the survey and compile the data. Recruitment of schools began in Fall 2008; 80% of high schools and 80% of middle schools in the state have agreed to participate.

Maine's Family Planning Association continues to work with some of Maine's racial and ethnic minorities. They have established a Somali mother's support group that focuses on adolescent health issues and will address how to talk with teens about sex.

Epidemiologists at the University of Southern Maine are working with Maine's TYAHP to map adolescent pregnancy rates and services available in the different regions of the state to identify areas of high need. In addition, district fact sheets on adolescent sexual health are being developed to distribute to personnel working in Maine's new public health districts to make them aware of the issue of teen pregnancy in their area. Family Planning representatives will also be members of teams that are conducting needs assessments in each district using the MAPP methodology developed by NACCHO.

c. Plan for the Coming Year

The Family Planning Association of Maine will continue to develop partnerships with racial and ethnic minority populations to address disparities. A planning process to ensure the most effective, science-based strategies are being applied to Maine will continue, with a focus on family life education and community-based pregnancy prevention strategies. A re-examination of intermediate outcome measures will be part of this process. These service numbers are likely to decrease if proposed budget cuts are approved.

Maine's Teen and Young Adult Health Program, in collaboration with Family Planning Association (FPA) of Maine will examine the results of the GIS mapping to help refocus resources to underserved areas.

FPA will work with districts around the state that identify adolescent pregnancy as a priority as they go through the MAPP process.

Schools districts are in the process of consolidating from 160 to 80. FPA will track these consolidation efforts and will assist the new districts if they need help with their health education programs.

Survey data from the Maine Integrated Youth Health Survey will be available in a web-based query system. This data will be analyzed and will be used to help in allocation decisions, especially if there are budget cuts to FPA.

The Maine Department of Education will include a section specific to HIV prevention education in its Linking Key Concepts to the Maine Health Education Standards document; a document that links key concepts in family life education, sexual assault prevention, and alcohol and other drug use prevention to the health education standards and performance indicators outlined in the 2007 Maine Learning Results.

Despite the recent increase in the teen birth rate in Maine in 2008, we project that Maine will continue to show progress on this measure. Our objectives for the next 5-years reflect a return to our previous low of 9.4 per 1,000 from 2007 and surpassing this rate. Although our objective is consistent with trends over the years prior to 2008, recent national trends and proposed budget cuts to services such as family planning may make achieving this objective challenging.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	34	56.6	58	60	60
Annual Indicator	56.6	56.6	56.6	56.6	56.6
Numerator	636	636	636	636	636
Denominator	1123	1123	1123	1123	1123
Data Source					Maine Child Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	60

Notes - 2008
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2008 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 third graders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The Maine Child Health Survey, which will include an oral health assessment of 3rd graders was administered in 2009. We anticipate having updated data for the 2010 MCHBG.

Notes - 2007
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2007 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 third graders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The Maine Child Health Survey, which will include an oral health assessment of 3rd graders, is due to be administered in 2009. We anticipate having updated data for the 2010 MCHBG.

The 2003 indicator reflects the percentage of Medicaid-eligible children ages 8 to 9 years who had at least one sealant placed on a permanent tooth. The data do not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

Notes - 2006
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

The 2006 indicator reflects 3rd grade data from the 2003-2004 Maine Child Health Survey. Data were not weighted due to a low response rate (17.6% for kindergarten and 3rd grade combined). A total of 1234 thirdgraders participated in the survey; sealant status was not obtained for 111 (9.0%) of these children. The results reported here are for the 1123 children for whom sealant status was known. Due to the low response rate and high percentage of missing sealant statuses, the results should not be considered generalizable to all 3rd graders in Maine.

The 2001-2003 indicators reflect the percentage of Medicaid-eligible children ages 8 to 9 years who had at least one sealant placed on a permanent tooth. The data do not include children who received dental care through a provider approved for claims bundling such as a federally qualified health center (FQHC) or a rural health center (RHC). The result is an under reporting of children insured through MaineCare who receive any dental services including sealants. The reduction from 2002 to 2003 may also be due to increased number of dental provider organizations that were approved for claims bundling.

Prior to 2001, the indicators for this objective came from the 1999 Smile Survey.

It is unknown at this time when the Maine Child Health Survey will be conducted again.

a. Last Year's Accomplishments
Maine uses data from the 2004 kindergarten/3rd grade Maine Child Health Survey (MCHS) to report on this measure. These data are not weighted due to a low survey response rate (18%) and may not be generalizable to 3rd graders in the state. It has been problematic for us to accurately track this measure. We are looking for additional data to provide insight into children's oral health in the state and whether children are receiving adequate preventive services. Based on data from the 2007 National Survey of Children's Health, 79.7% of Maine parents with children between the ages of 1-17 years reported that the condition of their children's teeth was excellent or very good. Among children in the age group that includes 3rd graders (6-11 year olds), only 8.3% reported not seeing a dentist for routine preventive care during the past year. Although the

MCHS provides useful information on children's oral health, it is only conducted every four years. Medicaid data from FFY 2007 show that 48.1% of EPSDT eligible children in Maine between the ages of 6 and 9 received dental services within that year. We received data on Medicaid claims for dental sealants from the Office of MaineCare Services. Among eligible children ages 6-9 years old, 17.3% had a claim for dental sealants; among children 6-18 years, 13.2% had a claim for dental sealants.

The Oral Health Program (OHP) maintained the dental sealant component of its School Oral Health Program (SOHP) that also supports classroom-based education and fluoride mouthrinse programs. In the 2007-08 school year, sealants were provided in 131 schools; 1335 2nd- graders received 4463 sealants. The retention rate varied from 86 to 94%.

The OHP hired a dental hygienist to fill a long-vacant Public Health Educator position in March. Because of a reduction to the OHP from the Preventive Health & Health Services Block Grant, this position was funded at half-time. The OHP successfully competed for a CDC 5-year State-Based Oral Disease Prevention Program grant (starting 7/31/08); the position was restored to full-time in October. The required activities of this cooperative agreement include refinement and evaluation of the OHP's school-based dental sealant program; the CDC funds the PHE to manage the dental sealant program. In her first few months, the PHE updated the OHP's educational resources, particularly those that can assist schools, other organizations and individuals in oral health promotion and dental disease prevention activities.

The State Oral Health Improvement Plan was published in November 2007. The existing Maine Dental Access Coalition, a broad-based stakeholder group, is responsible for ongoing monitoring of its implementation. Many of the Plan's strategies are intended to enhance state infrastructure and broad-based initiatives that can support increasing the proportion of Maine third-graders who have received sealants. Work on implementing these strategies was deferred while the Coalition focused on the work of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People, which met during 2008 and reported to the Governor on December 1. The Task Force, staffed by the Oral Health Program's director and the Commissioner of the Department of Professional and Financial Regulation, used the Plan as a resource; many of the Plan's strategies are reflected in the Task Force report.

The OHP competed for a 4-year grant from MCHB under the Targeted Oral Health Service Systems program that began in September 2007. The intent of the Kids Oral Health Partnership Project (www.kohp.org) is to increase the number of young children who receive oral health assessments and preventive dental visits and are identified as having a dental home.

The OHP Director participated in meetings to develop the Maine Integrated Youth Health Survey (MIYHS), assuring inclusion of oral health questions on parent and student surveys and an oral screening component for kindergarten, 3rd and 5th grade students. The survey was implemented during the 2008-09 school year.

The OHP encouraged new sealant components in the SOHP within the constraints of available funding. We were not able to bill MaineCare for sealants in 2008 to gain additional revenue to support school-based sealant programs, but we encouraged larger school-linked sealant programs to bill for these services to supplement our funding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain the number of schools with sealant programs	X		X	
2. Implement database or other tool for sealant program data collection and school oral health program		X		X

3. Determine efficacy of resuming billing as MaineCare provider for sealants				X
4. Collaborate on refinement of the Maine Integrated Youth Health Survey (includes an oral health component)			X	
5. Coordinate implementation of components of State Oral Health Improvement Plan				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHP continued to fund and coordinate the School Oral Health Program (SOHP) with 79 grants to schools, school districts and community agencies, providing oral health education in 242 participating elementary schools in the 2007-08 school year. Many children take part in a weekly fluoride mouthrinse program; in about half of participating schools, 2nd graders receive dental sealants at school. School eligibility for the SOHP is based on a formula that includes the proportion of students eligible for Free and Reduced Lunch and MaineCare, and the proportions of the community with fluoridated public water and whose family income is at the federal poverty level. The SOHP is thus directed toward schools where children are more likely to have difficulty accessing dental services, since socio-economic status is directly related to the ability to obtain dental care. Local SOHP directors, the majority of whom are school nurses, often work within their communities to find dental care for children without a regular source for that care.

In Spring 2009, the Maine Integrated Youth Health Survey was administered in elementary, middle and high schools around the state. The elementary school survey included questions on oral health and a dental screening by school nurses (or the OHP's hygienist) for children in grades K, 3 and 5. The k/3 survey yielded an overall response rate of 33%. Results should be available in Fall 2009 and will provide data for this indicator in the future.

c. Plan for the Coming Year

We have not changed Maine's objective for this measure, but plan to alter it after analysis of the 2009 Maine Integrated Youth Health Survey data. We will also continue to work with the Office of MaineCare to obtain claims data on sealant use and other preventive dental indicators.

The OHP's PHE will focus on coordinating the SOHP and the dental sealant component, and continue to update our educational resources and website. She plans to present a training session on implementing school-based sealant programs in the first half of the 2009-10 school year for school nurses, health coordinators and hygienists.

Our plan was to start a new 5-year grant cycle for the SOHP in FY09. In light of available resources and the reorganization of school districts, we extended our contracts until June 2009. As planned, we re-evaluated the components of the program and the basis for eligibility. In the biennial budget for FY10 and 11, funding from the state General Fund that has supported the SOHP was reduced by $250,000, leaving $127,816 to fund the SOHP and provide for certain operating costs; for FY10, an offset to this cut will use other available but one-time funds. As a result, eligibility for grants for the coming school year was critically reviewed. Grants will be made for one year. It is unclear how the SOHP will be sustained without significant restructuring and downsizing after FY10. We expect to devote considerable time during the first half of FY10 to exploring options in collaboration with various stakeholders and interested parties.

A school entrance oral health screening program, funded in the 2006 legislative session, was not

implemented due to staff constraints and some limitations imposed by the enabling statute. Additional legislative action in 2009 directs DHHS through the OHP, in collaboration with the Department of Education, to implement three pilot programs and report back in February 2010.

Related to the CDC grant, OHP staff will develop logic models and evaluation plans for seven program components, including our sealant program. We will also work with USM epidemiologists to implement an oral health surveillance plan and develop a burden of oral disease report by July 2010. The Kids Oral Health Partnership Project will move into full implementation, including a train-the-trainer initiative, give more attention to objectives related to cultural competency and children with special health needs, and begin focusing on sustainability planning.

Through a combination of resources, the OHP continues to support the Maine Dental Access Coalition, a broad-based stakeholder group. The Coalition has responsibility for overall monitoring of the implementation of the State Oral Health Improvement Plan. A number of the activities of the CDC's cooperative agreement will also involve the Dental Access Coalition; these activities include promoting collaborations that will support school-based oral health education and sealant programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.5	3.2	3	3	3.2
Annual Indicator	3.8	3.3	3.6	3.4	3.4
Numerator	45	38	40	38	
Denominator	1174980	1149644	1126308	1126269	
Data Source					Death certificates, Maine Vital Statistics Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.1	3	2.9	2.8	2.7

Notes - 2008
2008 death certification data are not yet available; 2007 data were used as an estimate.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819.

Notes - 2007
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. Data are from the Maine Office of Data, Research and Vital Statistics.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819. Using the HP definition, the rates for the past 2 five year periods are as follows:

2002-2006: 34/1126308=3.0 per 100,000
2003-2007: 34/1126269=3.0 per 100,000

Maine is below the Healthy People 2010 goal of 9.2 per 100,000.

Notes - 2006
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

The 2006 indicator is the 5-year average for 2002-2006. Due to the small number of motor vehicle deaths, a 5-year moving average has been reported since 1999 in order to control for potential large year-to-year random variation.

The ICD-9 codes included in this measure are E810-E825. This includes non-traffic motor vehicle crashes. This is not the same as the HP2010 objective codes, which only include E810-E819. The last 5 years of MV crashes among 0-14 year olds using this definition is:

1998-2002: 31/1235796 = 2.6 per 100,000
1999-2003: 34/1194879 = 2.8 per 100,000
2000-2004: 36/1174411 = 3.1 per 100,000
2001-2005: 32/1149644 = 2.8 per 100,000
2002-2006: 33/1126308=2.9 per 100,000

Maine is below the Healthy People 2010 goal of 9.2 per 100,000.

a. Last Year's Accomplishments
Motor vehicle crashes are the leading cause of death among children age 1-14 years in Maine. Maine's 5-year average rate of motor vehicle deaths among children age 14 and younger for 2003-2007 was 3.4 per 100,000 children. Maine's rate has generally been lower than the U.S. rate over time but this difference is not statistically significant. According to Maine's Youth Risk Behavior Survey (YRBS) the % of middle school students who never or rarely use a seat belt declined recently. Based on 2007 YRBS data 9.8% of middle school students reported never or rarely wearing a seatbelt when riding in a car. This is a significant decline from 10 years ago when more than 1 in 4 middle school students (26.5%) reported never or rarely wearing a seatbelt. Data from Maine's PRAMS reveal that almost all new mothers (>99%) report that their infants always ride in an infant car seat.

Analyses of Maine's Fatal Accident Reporting System (FARS) were conducted in Spring 2008. Results revealed that between 2002-2006, twenty-seven of the 39 MV-related deaths among children 0-14 years were captured in the FARS data system. Of these, 19 (70.4%) were using

some type of passenger restraint system, 6 (22.2%) were not using any restraint and 2 (7.4%) had unknown restraint use. All but one of the 14 (0-7 year olds) who were in cars, SUVs, minivans, or vans (excluding pickups) were seated in a back seat.

Data on Maine's motor vehicle death and injury rates led the Maine Injury Prevention Program to identify motor vehicle traffic crashes as a priority in their program plan.

There are 33 Child Safety Seat Program sites across the state. The program provided 2,106 car seats to families that met WIC income guidelines during FY08. Infant/toddler seats (birth-40 pounds) represented 56%, combination seats (2-4 age group) 18%, high back boosters (4-8 year olds) 19%, and 7% were high weight and special need seats. Special need seats included seats for children too small or too large for standard seats, harness systems for children with behavioral issues, and specially constructed seats for children with health related issues. Sites in the three largest metropolitan areas (Portland, Bangor and Lewiston) accounted for 35% of seats provided and 2 Lewiston sites provided slightly over 45% of those. The sites reported that 25 to 40 % of the recipients were Somali immigrants. The Portland site reported approximately 50% of their seats were provided to immigrant populations.

The Traffic Safety Educator (TSE) collaborated with the Maine Department of Education (DOE) and the Maine Association for Pupil Transportation to further develop and offer an awareness course related to transporting pre-school age children and children with special needs on school vehicles. 91 bus drivers, aides, mechanics and transportation directors were trained at eight locations in FY08.

DOE included a section in its Maine Learning Results Health Education Standards that addresses injury prevention and decision-making concepts that incorporate recreational vehicle safety, bus safety, passenger vehicle safety, and use of seat belts.

Maine's Home Visiting Program conducts safety assessments every 6 months and provides information to families related to car safety. Families are encouraged to have their car seats checked by a certified car seat installer. The assessment covers four areas: children are never left alone in the car; a child safety seat is placed in the back seat facing in the appropriate direction for age and weight; a child safety seat is used on every ride; and caregivers buckle up on every ride. The FY08 assessment revealed that 86% of families scored safe on all four categories. In the remaining 14%, most of the unsafe scores resulted from adult failure to use their seatbelt every time.

3 National Highway Safety Administration CPS technician classes were held during FY08. A total of 41 new CPS technicians received training, 11 of which were law enforcement officers.

More than 16,312 pieces of injury prevention promotional materials related to traffic safety were distributed to organizations throughout the state. A minor change in the CPS law required that printed materials be updated and revised. This, as well as funding constraints, has lead to fewer materials being provided. Some materials are being made available via the website and more material requests are being sent via email.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide child safety and booster seats to children birth to 8 years old		X	X	X
2. Present to groups and organizations on the importance of child passenger safety		X		X
3. Provide support and education to fitting stations				X

4. Collect data on misuse and number of seat checks				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY09 the TSE role was changed to one of providing statewide coordination of activities. This change resulted in the TSE no longer conducting trainings. The change was made to allow the TSE to provide leadership and coordination of CPS activities that ensure a comprehensive CPS Program throughout the state.

We continue to work with the Children's Safety Network (CSN) to evaluate CPS Technician Training. The evaluation is being conducted to investigate high rates of CPS technicians not re-certifying after 2 years and to ensure parents are receiving the best education on transporting their children safely. A survey designed to measure knowledge retention and skills of CPS technicians was administered in April. Results will be used to enhance delivery of CPS training and devise ways to better support technicians after certification. The CSN is interested in learning more about Maine's work to potentially highlight in a future nationwide correspondence as Maine is perhaps the only state to undertake this level of child passenger safety evaluation.

In June 2009 the MIPP sponsored 2 symposiums on motor vehicle safety among youth; 1 focused on teen drivers and the other on child passenger safety. CPS technicians and instructors, as well as, representatives from education, health care, law enforcement, and childcare providers attended the Child Passenger Safety Symposium. The key outcome of the day was to identify initial steps and strategies to enhance CPS services in Maine.

c. Plan for the Coming Year

The child motor vehicle mortality rate for 2003-2007 was not significantly different than the prior year therefore we have maintained our objectives for this measure, anticipating improvement over time.

MIPP will continue the following activities during FY10.

· Provide child safety seats and technical assistance to safety seat programs statewide. Provide seats to families in need including those with special needs.

· Continue to work with the media and legislators to educate the public on child passenger safety issues.

· Provide annual child passenger safety training to Child Passenger Safety Seat Program staff at various locations around the state via telecommunication technology.

· Continue to provide educational materials and resources on child passenger safety to professionals, advocates and the general public.

· Maintain a current list of locations of car seat check locations and car seat distribution sites on our website, on 2-1-1, and on the Bureau of Highway Safety website.

· Continue work on program website for dissemination of prevention information including prevention resource contacts, data, training opportunities and links to other Maine and national injury prevention resources.

· Continue to educate school transportation personnel on the intricacies of transporting pre-

school aged and
special needs children on school buses.
· Coordinate activities with Safe Kids Maine and Falmouth Fire-EMS in promoting child passenger safety.
· Convene site managers once yearly to celebrate their accomplishments and provide program and car seat
updates.

DOE will hold its 25th annual Maine Schoolsite Health Promotion Conference in June 2010. Motor vehicle safety topics will be included.

DOE will continue to participate in programming with the Maine Injury Prevention Program and Coordinated School Health Program. Partnerships will be expanded with the Department of Transportation Safe Routes to Schools Program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			38	41	47
Annual Indicator		36.9	40.6	46.1	41.2
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44	45	46	47	48

Notes - 2008
Data for the 2008 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2008 indicator represents the percent of children in Maine, born in 2005, who were breastfed for 6 months. Data from the 2006 and 2007 surveys were combined to obtain this estimate. The data are provisional until the 2008 results are added.

Notes - 2007
Data for the 2007 indicator are based on the National Immunization Survey. Starting in 2006, the NIS changed the way they report breastfeeding rates and some of the breastfeeding questions on the survey. Breastfeeding rates are now reported by year of child's birth, rather than by survey year. Therefore, the 2007 indicator represents the percent of children in Maine, born in 2004, who were breastfed for 6 months. Data from the 2005, 2006 and 2007 surveys were combined to obtain this estimate.

Our objectives were changed to be aligned with the new reporting methodology.

Notes - 2006
Percent of mothers who breastfeed their infants at 6 months of age.

Data from the 2005 National Immunization Survey; 2006 data are not available.

a. Last Year's Accomplishments
There are four surveillance systems that include Maine breastfeeding data; the CDC Pediatric Nutrition Surveillance System (PedNSS) is the data source specific to the WIC population. The other data sources include the CDC Pregnancy Risk Assessment and Monitoring System (PRAMS), the Maine Newborn Breastfeeding Surveillance System (breastfeeding rates at hospital discharge), and the National Immunization Survey (NIS). Maine has chosen to use the National Immunization Survey because it is the only data source that is generalizable to all women in Maine and includes women who are at-least 6 months postpartum.

The NIS now presents breastfeeding information according to the child's year of birth, rather than the year the respondent was interviewed. Due to NIS changes to data presentation, the most recent data available for this measure are based on children born in 2005. According to these data, 41.2% of children born in Maine in 2005 were breastfed for at least 6 months and 12.3% were exclusively breastfed for 6 months. This percentage is lower than the national average, but not statistically lower. Our ranking decreased from the 14th highest breastfeeding rate at 6 months in the United States to the 29th . However, the 2005 NIS data are provisional. According to NIS data from 2000-2004, Maine's breastfeeding rate has fluctuated over time. Maine PRAMS data do not reveal a discernable trend in breastfeeding initiation between 2000 and 2007. Maine 2007 PRAMS data indicate that 78.2% of Maine mothers initiated breastfeeding and 57.5% were still breastfeeding when they completed the survey, which is usually when their infants are about 3 months old.

In June 2008 the CDC released the results of the Maternity Practices in Infant Nutrition and Care Survey that assesses hospitals and birthing centers practices related to encouraging breastfeeding. Facilities were scored based on factors such as mother-newborn skin-to-skin contact after delivery, early breastfeeding initiation, instruction on breastfeeding, not giving pacifiers to newborns, and breastfeeding support after discharge. 91% of Maine facilities responded to the survey. Maine's overall score on the survey was 77 of a maximum 100 the third highest in the U.S. According to the CDC's 2008 Breastfeeding Report Card, 16.8% of births in Maine were at Baby Friendly Hospitals, the highest percent in the nation.
Programs in Maine focused on improving breastfeeding rates among new mothers are WIC, Home Visiting (HV), and Public Health Nursing (PHN).

There are 4 breastfeeding peer counselors in 2 local WIC agencies. Peer counselors are mothers who have successfully breastfed their infants and are trained to offer encouragement, information and support to mothers enrolled in WIC. Breastfeeding peer counseling was implemented in one additional clinic during FY08. The Breastfeeding Peer Counselor Program has demonstrated positive outcomes for breastfeeding mothers.

HV actively encourages new mothers to breastfeed and links mothers to resources such as hospital breastfeeding classes and lactation consultants. Through WIC, the HV has increased the number of lactation counselors embedded in HV programs. In FY08 the % of HV families that were breastfeeding at 6 months was 38%. Overall the exclusively breastfeeding at 6 months rate was at 16.3%. During this time period the family is seen minimally once a month but some may be seen weekly. At every visit there is a check in to see if the mother is breastfeeding exclusively. HVs focus with prenatal and postpartum mothers is attempting to extend breastfeeding. Prenatal enrollment is slightly lower than postnatally. Those enrolled prenatally are frequently those PCPs have concerns about; i.e. food insecurity, very young.

Due to both the geography of the state and limited PHN staff, the Women and Children's Preventive Health Services Program funds 3 Community Health Nursing (CHN) contracts to provide home health nursing services to mothers and children in portions of central and southern Maine. During FY08 CHN provided 10,778 visits to 4,268 clients. Of the 10,778 visits, 977 were at risk parenting visits, 5,742 children visits, 84 children with special needs visits, 3,622 postpartum visits, and 353 prenatal visits.

During FY08 PHN provided 17,823 visits to individual clients. Of these visits 4,940 were children, 2,744 parenting, 2,535 postpartum, 352 prenatal, 78 lead, and 1 infant death, for a total of 10,650 individual visits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate data sources and improve the accuracy of WIC breastfeeding data				X
2. Offer training opportunities for WIC counselors, public health nurses and home visiting on the development of counseling and clinical skills to support optimal breastfeeding practices				X
3. Enhance the WIC breastfeeding peer counselor programs				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Nutrition Program is conducting statewide trainings with local agencies on new food package changes that will result in changes around initiation rates for breastfeeding. In the 1st month of a baby's life there can no longer be partially breastfed babies. Mothers have to choose whether or not they want to breastfeed or receive formula from WIC. The maximum amount of supplementation a breastfed baby can receive in the first month of life will be 1 can of formula. The WIC Program is developing an educational document to assist moms in getting successfully past the first 30 days of breastfeeding. This effort, we hope, will prevent moms from choosing not to breastfeed out of concern they may not be able to exclusively breastfeed. Those choosing to breastfeed will receive an enhanced food package, as well as, a larger supply of infant meats after 6 months of age.

In FY09 eleven local WIC agency staff members plan to complete Certified Lactation Counselor (CLC) training. With the addition of these 11 staff there will be approximately 42 local WIC agency staff trained as CLCs and 4 trained as International Board Certified Lactation Consultants.

c. Plan for the Coming Year

Data on breastfeeding among children born in 2005 as calculated from the National Immunization Survey are still preliminary and requires an additional year of survey estimates before being finalized. However, based on the most recent estimate available, we have adjusted our objectives and hope to increase our breastfeeding at 6-month rates by at least 1% each year through 2011.

The WIC Program will focus on attaining two goals: 1) Maine WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC participants. The breastfeeding indicators that reflect these goals are: 1) increase the number of WIC mothers who are breastfeeding their babies at six months, and 2) provide pregnant and/or breastfeeding women access to a qualified lactation counselor.

The WIC Program will focus on increasing the number of WIC mothers who are breastfeeding their babies at six months, and on providing pregnant and/or breastfeeding women access to a qualified lactation counselor. The Program will continue to collaborate with the local WIC agencies and the Maine State Breastfeeding Coalition to enhance breastfeeding promotion and support strategies.

The WIC Program will maintain the two local agency breastfeeding peer counselor programs with one of the agencies expanding the program to include another clinic. The WIC Program will continue to provide technical assistance to the local agency breastfeeding coordinators and ensure that data is collected according to standard procedures and methods.

The WIC Program will continue efforts to increase this measure through food package changes; promotional efforts that include tote bags and baby undershirts with positive breastfeeding messages, baby bibs with graphics of fruits and vegetables; and increase physician involvement through outreach.

The Home Visiting Program will continue efforts to increase prenatal enrollment and work with WIC to help reinforce messages on breastfeeding.

Public Health Nursing is working on improving their data system to track improvements in client outcomes, such as breastfeeding initiation and duration.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	90	91	96.5	96.8
Annual Indicator	88.9	91.7	95.1	97.1	96.1
Numerator	12208	12827	13318	13560	12974
Denominator	13733	13988	14009	13969	13500
Data Source					Maine Newborn Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97	97.2	97.4	97.6	97.8

Notes - 2008
MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. The 2005-2008 estimates include all hospitals.

In 2005, babies who had a hearing screen record but both ear results were 'N/A' were counted as having been screened. For 2006-2008 data, we did not count those as screens to reflect more accurate reporting.

Notes - 2007
MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. The 2005, 2006, and 2007 estimates include all hospitals.

In 2005, babies who had a hearing screen record but both ear results were 'N/A' were counted as having been screened. For 2006 and 2007 data, we did not count those as screens to reflect more accurate reporting.

For 2003 and prior years, this indicator reflected the percentage of newborns who had *access* to a hearing screen before hospital discharge. Beginning in 2004, the indicator reflects the percentage of newborns that were actually screened.

Notes - 2006
MNHP does not maintain data on those who are screened prior to discharge from a birth facility, only screened/passed/refer by age. Therefore, the numerator for this indicator reflects infants screened by 1 month of age, the closest proxy we have to screening at discharge. The 2005 and 2006 estimates includes all hospitals.

In 2005, babies who had a hearing screen record but both ear results were 'N/A' were counted as having been screened. For 2006 data, we did not count those as screens to reflect more accurate reporting.

For 2003 and prior years, this indicator reflected the percentage of newborns who had *access* to a hearing screen before hospital discharge. Beginning in 2004, the indicator reflects the percentage of newborns that were actually screened.

a. Last Year's Accomplishments
The Maine Newborn Hearing Program (MNHP) was established in 1999. Since January 2003, every birthing facility has been required to report to the MNHP the number of babies born in the facility, the number of newborns who received a hearing screen, the result of the hearing screen and the number of newborns whose parents declined hearing screening.

An electronic data tracking system, ChildLINK links newborn hearing screening data with the electronic birth certificate, enabling the MNHP to verify that every baby born in Maine has a newborn hearing screen and to track follow-up services regarding audiological evaluations and referrals to and participation in early intervention services. Birthing facilities and audiologists have the capability of submitting screening and diagnostic data via this web-based system.

There are currently 31 birthing facilities in Maine and all receive site visits, regular communication with the MNHP and technical assistance as appropriate. CY08 financial constraints resulted in 1 hospital and 1 free standing birthing facility ceasing to offer maternity services. In CY07, 25 of the 33 birthing facilities in Maine had a greater than 98% screening rate with 3 facilities obtaining 100%. Only 4 facilities had a less than 95% rate. The remaining 4 facilities had rates between 95% and 98%. It is unlikely that all the birthing facilities will reach the 100% screening rate

because the rate is based on the number of live births at each facility and does not take into account parent refusal or death of a baby shortly after birth.

Data submitted to ChildLINK during CY08 indicated 13,500 births occurred in Maine. Of these, 13,162 (97.5%) were screened for hearing loss. Of these, 12,974 (98.7%) were screened by 1 month of age. Of the 13,162 screened, 217 (1.7%) did not pass the screening. To date, we have received 120 (55.3%) reports on those referred to an audiologist. Of the 120 reports, 8 were identified with hearing loss. We received reports on 4 who passed or missed their newborn hearing screen and were identified with hearing loss. Of the 8 babies identified with hearing loss, we received reports that 1 child has Individual Family Service Plans with Child Development Services, our Part C provider in Maine.

Effort to improve data quality resulted in collaborative work with other New England states to develop a means to share hearing screening, evaluation and intervention data for children who did not receive these services in their birth state. As a result, LD 2106 "An Act to Enhance the Newborn Hearing Program" was introduced, and became law effective in July 2008. The law allows the MNHP to participate in a regional database with the other New England states.

Maine audiologists play an important part in providing diagnostic evaluations to infants who screen positive for hearing loss. A challenge to the MNHP has been a lack of results reported back to the Program. The Program worked with the Maine Academy of Audiologists (MAA) and MNHP Advisory Board to submit legislation (LD 1142) requiring that all hospitals licensed in the State and other providers of services that have established hearing screening or diagnostic procedures for newborn infants and children up to 3 years of age report to the department all data on hearing screening, evaluation, and diagnoses of newborn infants and children up to 3 years of age. The law effective September 2007 mandates all providers of hearing diagnostic procedures report the results of their evaluation and diagnosis to the MNHP. As a result of this legislation, the MNHP worked closely with the MAA to revise the audiology reporting forms to better serve MNHP requirements and meet some audiologist reporting concerns. The new reporting form was implemented on March 1, 2008.

LD 2295 became effective July 2008 requiring that when a newborn receives a newborn hearing screening result of refer, the facility that performed the screening schedule the newborn for a follow-up appointment with an audiologist.

In CY08, 93 (42.9%) of the 120 children who did not pass the newborn hearing test had "unknown" results or were lost to follow-up. The % of children lost to follow-up has been decreasing over time. In CY06, 62% were lost to follow-up. The results from CY08, although preliminary, are similar to CY07 (47.3%) and showed a marked decrease. We anticipate this decline to continue with the implementation of recent legislation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor compliance of hospitals and audiologists reporting via the electronic reporting system				X
2. Provide tracking of newborns who do not pass the hospital screen		X		
3. Educate providers about the mandated requirement of providing results of audiological evaluations to the Newborn Hearing Program				X
4. Collaborate with CDS, Part C agency to facilitate referrals into early intervention		X		
5. Establish a Models for Improvement Team				X

6. Continue to facilitate the Newborn Hearing Program Advisory Board				X
7. Evaluate comprehensive screening and service system				X
8. Create an educational brochure on hearing screening to be provided to prenatal classes as well as health care providers who offer obstetric services				X
9. Work with Maine nurse midwives to improve access to newborn hearing screening for those children born at home				X
10.				

b. Current Activities
Analyses conducted on newborns not screened for hearing indicate, newborns not screened were more likely to be born outside of a hospital and births were more likely to be attended by someone other than a physician. 2 hospitals were identified as having lower screening rates. Results will be used to develop strategies to improve overall newborn hearing screening rates.

CSHN Program objectives are to ensure that NICU infants receive a hearing screen as soon as medically appropriate, that any known risk factors for late onset, progressive, or acquired hearing loss are indicated on the infant's hearing screen record, that the child's primary care provider is identified and provided to MNHP, that the medical home and the child's family are aware of the importance of ongoing audiological exams when indicated and that the results of any diagnostic audiological exams are reported to MNHP. Using the National Initiative for Children's Healthcare Quality (NICHQ) Model for Improvement (improving children's health by improving the systems that deliver healthcare through adopting best practices and ensuring high quality care), CSHN will focus on newborns that are admitted to the Eastern Maine Medical Center (EMMC) NICU, either from within EMMC or from secondary/tertiary facilities. The Team consists of the CSHN Director, MNHP Manager, a parent consultant, audiologist consultant, and a nurse educator, nurse practitioner and audiologist from EMMC's NICU.

c. Plan for the Coming Year
Preliminary data for 2008 indicates that Maine is maintaining its level of newborn hearing screening while increasing its rate for follow-up testing, evaluation, diagnosis and enrollment in appropriate early intervention services.

During FY10, MNHP plans to continue to implement and monitor quality assurance and quality improvement plans in the management of a statewide universal newborn hearing system, improve audiology reporting and access to early intervention services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	10	10	10	7.5	8
Annual Indicator	6	6	7	5.6	5.6
Numerator					
Denominator					
Data Source					Current Populatiop Survey 2006-2007
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.6	5.6	5.5	5.5	5.5

Notes - 2008
2008 data for this indicator are not yet available. The 2007 indicator is used as a proxy.

The 2007 indicator reflects analysis of the state data from the pooled 2006 and 2007 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Notes - 2007
The 2007 indicator reflects analysis of the state data from the pooled 2006 and 2007 Current Population Surveys conducted by the US Census and reported on the statehealthfacts.org Web site. The indicator is for children aged 18 years and under.

Our objectives reflect anticipated future trends. Insurance rates have been increasing with the result that families are being asked to assume larger co-pays and deductibles. Anecdotal information suggests families are beginning to drop their insurance coverage as a result of higher out of pocket expenses. We anticipate these external forces will create the likelihood of increased uninsured rates in future years.

We have seen declines in uninsured children in recent years. Our objectives in the future are influenced by persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform, Dirigo Health Plan.

Notes - 2006
Percent of children without health insurance.

Our objective of 9.5% by 2011 is influenced by persisting economic uncertainty mixed with freezes in enrollment in Maine's new health care reform, Dirigo Health.

Not enough time has passed to see the longterm impact of increasing cost of living (heating oil, gas, rent, and food) expenses. In addition, we do not know at this time what the impact of the Dirigo health changes will be. During the most recent legislative session, funding was not approved to expand enrollment. As a result, as of July 1, 2007, enrollment of individuals in Maine's Dirigo health program was temporarily suspensed; as of Sept 1, 2007, enrollment will be suspended for small businesses and self-employed as the program looks for ways to cut costs. Furthermore, the Deficit Reduction Act opened the door for states to take the opportunity to make changes in medicaid packages. Maine has not made any changes as yet to MaineCare and we do not know what the impact will be if this occurs.

We will continue to work with the Governor's Office on Health Policy and Finance to monitor over time to determine the anticipated direction of this trend.

a. Last Year's Accomplishments
Since 1996 there has been a considerable decrease in the % of Maine children without health insurance. According to the 2008 Current Population Survey, 5.1% of children under age 18 in Maine in 2007 were without any health insurance. About 35% were covered by MaineCare and 67% were covered by private health insurance. The US child uninsured rate was 11.0% in 2007. Maine has one of the lowest uninsured rates in the U.S. By ensuring access to school-based

health centers, home visiting, and public health nursing, Maine's Title V program is working to decrease or maintain the percent of children without health insurance in the State.

School-based health centers (SBHCs) provide a safety net for children who might not otherwise seek needed health care services. While not every community has created the necessary partnership between health care providers and schools, there continue to be 27 schools with SBHCs in the state. The Teen and Young Adult Health (TYAH) Program provided base funding for 20 SBHCs. 7,994 students were enrolled in these 20 funded school-based health centers (SBHCs) in Maine in FY08. There were 13,936 encounters, 31% of all visits were for mental health services, 31% of the primary diagnoses at medical visits were for preventive services, and approximately 51% of the users had a preventive care visit. About 51% of users were screened for major adolescent risk behaviors including tobacco use, physical inactivity, poor nutrition, sexual activity, substance abuse, depression and behaviors connected to unintentional injury. Changing adolescent health behaviors can be challenging but data from the SBHCs shows that when unhealthy behaviors were identified, intervention was possible and change did occur. For example, of the 204 identified as tobacco users, 104 received treatment that resulted in 13 reducing or quitting tobacco use, and of the 324 identified with poor nutrition, 270 received an intervention with 22 showing improvement.

92% of SBHC enrollees had an identified primary care provider, 85% of those enrolled in SBHC's had insurance (public or private), 47% with MaineCare, while 4% had no insurance. SHBC staff assisted those children with no insurance in getting connected with insurance providers. Data on SBHC services continued to improve in quality and detail through the assistance of an in-state helpdesk, and contracted data analysis services.

99.5% of children enrolled in the Home Visiting Program in FY08 had access to a primary care provider and 98.6% had health insurance, 67.6% through MaineCare. Key to this high rate of insured children is the referral for eligibility determination made during the initial family engagement. The remaining 1.4% of uninsured children represent those in the process of applying for MaineCare, those who are in the period of time before private insurance becomes valid, those whose children may be in state custody, or those whose circumstances are complex because of job loss and subsequent loss of insurance.

During FY08, of the 4,228 clients served by Community Health Nursing (CHN), 42% were insured by MaineCare, 47% had private insurance, and 1% had no insurance. The focus of CHN is to ensure clients obtain access to a primary care provider to obtain the required health care. They do monitor whether or not the client has insurance and provide clients with information on how to obtain insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBHC providing assessment of insurance status, education and assistance in enrollment		X		
2. Monitor changes in insurance coverage				X
3. Monitor for changes in MaineCare services and work with the Office of MaineCare Services to facilitate MaineCare reimbursement for adolescent health services				X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Base-funding from state Maternal and Child Health matching funds and the Fund for a Healthy Maine (Master Tobacco Settlement funds) for 20 SBHCs continues to assist in maintaining access to services as the SBHCs and sponsoring agencies face more stringent budgets. On average, this funding provides 27% of the average SBHC budget. A small portion of the MCHBG allows these sites to provide services to uninsured and underinsured students without impacting the ability to bill MaineCare and other insurers, which are projected to provide 17% and 8% of SBHC revenues respectively.

As SBHC's transition to electronic medical records (EMR) new data collection formats are causing increased challenges to collecting outcome data. Our first experiences with this demonstrated that it is possible, but requires careful quality checks.

The TYAHP continues to advocate with Kid's Count to provide adolescent specific data on uninsured rates. Past national data suggests that adolescents have higher rates of un-insurance.

The Maine Association of Health Plans and SBHC Reimbursement Study is completed. The study purpose was to look at the costs and benefits of providing reimbursement to SBHC's without a prior primary care provider referral or approval. We anticipate a final report by late summer.

c. Plan for the Coming Year
The TYAHP will fund 19 SBHC grants in FY10, continue the evaluation contract to support better data collection, seek opportunities to improve services and sustainability of SBHCs, including promoting preventive health, addressing behavioral health issues, and expanding partnerships.

Home visiting programs not only document the insurance status of enrolled children but also track reasons why children are not insured. In some instances parents choose not to enroll in public health insurance when they initially begin to participate in the Home Visiting Program. Because home visitors are trained to engage families in the steps to promote child health and well being, each family's barriers are addressed individually, and home visitors may assist families in the application process.

Despite these efforts, in Maine, this is a measure for which we can't expect consistent improvement over time. State revenues continue to decline and the economic forecast does not indicate any improvement. As the Executive and Legislative branches work to balance the budget, efforts have been made to retain MaineCare (Medicaid) services for children. The recently approved budget contains a large number of cost saving initiatives through the MaineCare budget, most to be implemented through emergency legislation that went into effect July 1, 2009. Title V staff are beginning to learn about some initiatives that will impact the Title V women and children population. Two initiatives involve a restructuring of codes and payments for family planning services, and elimination of many targeted case management billing codes. Conversations with MaineCare leadership indicate details of these and other initiatives will be provided in the next three months. While children and pregnant women will continue to be insured through MaineCare, the range of covered services appears to be decreasing. Children covered through private insurance are at risk of losing coverage should their parents become unemployed. Because the state economic forecast remains level, at best, we anticipate the number of uninsured children to increase.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	31	30
Annual Indicator		33.6	33.1	38.0	37.9
Numerator		3461		4685	5016
Denominator		10298		12337	13239
Data Source					Maine WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	36	35	34	33	32

Notes - 2008
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2010. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2007
Data are from the Maine WIC Program. The WIC program is undergoing a database revision due to problems with the current system. The new database will be active in summer 2010. We may see a change in the value of this indicator in future years if the new system improves data collection and database useability.

Notes - 2006
Data are CY2006 PedNSS.

a. Last Year's Accomplishments
Maine uses data collected by the local WIC agencies to determine the percent of children > 2 years enrolled in the WIC Program at or above the 85th percentile for weight. Based on this data, 38% of children in 2007 and 38% in 2008 were overweight or obese. This is slightly higher than the 33.1% reported last year.

In FFY04, the Maine WIC Nutrition Program implemented nutrition education procedures that presented a change in philosophy from nutrient and diet focused education to helping parents recognize the importance of a healthy parent-child feeding relationship. Maine WIC staff continued to foster an emphasis on healthy behaviors and family meals.

The guiding principle for VENA is to strengthen and realign the primary purpose of WIC nutrition assessment to personalizing nutrition services in order to maximize the impact WIC nutrition services have for participating families.

A major initiative that the Maine WIC Nutrition Program initiated during FY08 was the implementation of Value Enhanced Nutrition Assessment (VENA) for all Local and State Agency WIC Staff. VENA was developed jointly by the Food and Nutrition Service and the National WIC

Association to improve nutrition services in the WIC Program by establishing standards for the assessment process used to determine WIC eligibility and to individualize nutrition education, referrals, and food package tailoring. During FY08 basic skill training was provided in several competency areas including: rapport building, critical thinking, cultural competency, stages of behavior change, health-outcome assessment, emotion-based counseling, nutrition knowledge, and breastfeeding.

Research indicates the longer infants are breastfed the lower the probability of being overweight. The Maine WIC Nutrition Program continued to provide breastfeeding education to all pregnant women and encouragement and support to breastfeeding women and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evaluate on-going VENA training provided to local agency staff				X
2. Evaluate WIC agency contract indicators to achieve the WIC Goals				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maine WIC Nutrition Program is working with local agencies on the VENA initiative, initiated by the Food and Nutrition Service of USDA, to provide guidance and structure to the WIC nutrition assessment process, implement the WIC Special Projects Grant to deliver VENA through improved cultural and linguistic competence of WIC staff. These initiatives will provide some infrastructure for enhancing the focus of WIC's counseling and education activities.

Planning is underway for food package changes that will better meet the nutritional needs of WIC participants. Implementation is planned for October 1, 2009. Training on the changes will be provided to all WIC agencies.

The Maine WIC program is engaged in discussions with the Maine Physical Activity and Nutrition Program (PAN) on ways to incorporate healthy eating messaging in local WIC agency offices. Initial discussions centered on placing colorful posters or pictures promoting nutrition and physical activity messages on reception area walls to impact client awareness and knowledge.

The program is also working to implement a new data system. This system will make it easier for local agencies to collect data on this measure and help improve the quality of the data. It is anticipated that the new system will be operational in summer 2010.

c. Plan for the Coming Year

The WIC Program will focus on attaining two goals: 1) Maine WIC participants will have improved health and well-being through access to quality WIC nutrition services; and 2) the Maine WIC Nutrition Program will provide effective, efficient and culturally sensitive services to all WIC

participants. The nutrition education indicators outlined in the WIC agency contracts that reflect these goals are: 1) increase the number of WIC participants who are at a healthy weight, and 2) ensure that all WIC staff reinforce VENA methods in participant nutrition assessments.

The Maine WIC Nutrition Program will focus on reducing the number of WIC children who are overweight. The Program will continue to partner with the Maine Physical Activity and Nutrition Program to determine the feasibility of developing posters or pictures depicting healthy messages, collaborate with Local WIC Agencies, as well as, other partners to enhance strategies that will help to reduce the rate of overweight children in Maine.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			19	17	16.5
Annual Indicator		20	17.5	19.9	19.9
Numerator					
Denominator					
Data Source					Maine PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19	18	17	16	15

Notes - 2008
Data for this measure are from the Pregnancy Risk Assessment Monitoring System (PRAMS). 2008 PRAMS data are not yet available. Therefore, 2007 data are used as an estimate.

Notes - 2007
The data source for this measure is the 2007 Pregnancy Risk Assessment Monitoring System.

PRAMS data are weighted. Therefore the numerator and denominator for this measure are not presented.

Notes - 2006
The data source for this measure is the Pregnancy Risk Assessment Monitoring System. Data for 2006 are unavailable. Therefore, 2005 data are used as an estimate for 2006.

PRAMS data are weighted. Therefore the numerator and denominator for this measure are not presented.

a. Last Year's Accomplishments
The Maine Pregnancy Risk Assessment Monitoring System (PRAMS) reported in 2007 that 19.9% of pregnant women smoked during the last three months of pregnancy. This is higher, but not statistically higher, than the rate in 2006 and 2005. Despite no significant changes in the %,

the Partnership For A Tobacco-Free Maine (PTM) remains committed to reducing the percentage of pregnant women who smoke. Collaborations with the March of Dimes, Perinatal Outreach Nurse Educator, and Maine CDC programs remained strong. The Center for Tobacco Independence (CTI) continued to assist pregnant women quit through the Maine Tobacco HelpLine (MTHL) and continued training providers to implement the "Treating Tobacco Use and Dependence Clinical Practice Guideline" (updated 2008).

The Every Mother's Wish (EMW) Program for pregnant women discontinued in 2007, was updated in FY08. Participants in 3 focus groups indicated they did not relate to the EMW video, messages or materials. The women indicated the EMW program would not motivate them to quit. However, a focus group held with OB/GYN doctors reported that support materials and fax referrals to the MTHL were important, and indicated they would use the kit. PTM has received numerous requests from providers for the EMW Program, an indication that resources should be devoted to developing provider materials. CTI also requested new materials for Clinical Outreach Trainings, that will also include fax referrals to the MTHL.

The MTHL continued to offer quitting materials and coaching sessions to pregnant women who smoke. The number of callers to the HelpLine was tracked through a series of 3 questions. 60 callers to the HelpLine during FY08 were currently pregnant, 45 were planning a pregnancy within 6 months, and 22 were currently breastfeeding. These numbers were lower than FY07, (77, 45 and 22 respectively) possibly due, in part, to the termination of the EMW Program. Fewer calls to the MTHL during FY08 could also be attributed to less media about the MTHL (Radio, newspapers and TV advertisements). Evaluation has shown that when media is running, the MTHL received an increased number of calls.

PTM collaborated with the New England Rural Health Roundtable (NERHRT) to look at the issue of smoking during pregnancy. In 2007 the NERHRT released Rural Data for Action: A Comparative Analysis of Health Data for the New England Region that identified rates of maternal smoking during pregnancy in women living in rural areas was nearly twice as high, when compared to those living in non-rural New England. Through this initiative Maine had an opportunity to collaborate with other New England programs to study the issue and together develop intervention(s) to help pregnant women stop smoking. In addition, analyses were conducted specific to the issue of rural vs. urban smoking rates in Maine. The analysis supported the rural-urban difference in smoking rates in Maine. However, after adjusting for socio-economic status, the findings suggested that the relation between rurality and maternal smoking during pregnancy was largely accounted for by differences in income across levels of rurality. The results and suggested interventions of the subgroup will be incorporated in a white paper to be released in FY09.

PTM began a strategic planning process to address populations disproportionately affected by smoking. 9 workgroups were developed (LGBT, Native American, Behavioral Health, Low SES, Youth, 18 -- 24, New Immigrants, Pregnant Women, and Chronic Disease). The plan will be completed in early FY10.

PTM trained 100 WIC staff to help their clients quit tobacco (5 regional trainings). The focus was pregnant moms, new moms and moms with children. The presentation included background information on tobacco use, nicotine addiction, second and third hand exposure, and tobacco cessation treatment. Specific MTHL materials and local resources to help clients quit were provided. WIC staff were introduced to the District Tobacco Coordinator (DTC) and Clinical Outreach Specialist in their region as a resource for on-going support. The DTCs are trained to use the WIC presentation with other providers, including Domestic Violence shelters, Rape Centers, TANF, Career Centers, YMCA/ YWCA and Homeless Shelters. The intent was to reach pregnant women who smoke to utilize these services. To help keep tobacco as a priority WIC staff are allowed to use the fax referral system to the MTHL for their clients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Redesign and promote program materials based on NERHRT results and PTM strategic plan		X		
2. Provide Basic Skills Trainings for healthcare, social service, and other providers				X
3. Promote the Maine Tobacco HelpLine through print and other media		X	X	X
4. Collaborate with MCH programs and MaineCare services to increase coverage for tobacco cessation treatment for pregnant women referrals		X	X	
5. Promote programs and messages at the local level through HMP's and DTC's		X	X	
6. Collaborate and expand partnerships with WIC, Women's Health Initiative, Home Visiting and Office of Substance Abuse to address quitting with their clients		X		X
7. Increase capacity of local organizations and grantees to address priority populations				X
8. Evaluate programs and track prevalence rates				X
9. Provide proactive counseling to all pregnant women through the Maine Tobacco HelpLine and face to face coaching			X	
10.				

b. Current Activities

A Maine CDC intern completed a literature search on rural pregnant women who smoke and interviewed various NE programs about their specific interventions. Results indicated few interventions were implemented. PTM and the NERHRT subgroup recruited rural pregnant women for telephonic focus groups in Spring 2009. The majority were smokers, had a high school degree, moved often and were Medicaid recipients. Results will be incorporated in a white paper and materials will be developed.

CTI is reviewing and incorporating into the MTHL script parts of The American Legacy Foundation's new QuitLine protocol, Postpartum Protocol Script for Tobacco Quit-Line Counseling (March, 2008). The purpose is to reach and encourage postpartum mothers to quit, not relapse and create smoke free environments.

Three rural health clinics are piloting a face-to face Intensive Treatment program to address tobacco treatment options for smokers whose needs are not being met by either telephonic counseling or brief provider-based interventions (co-morbidities, mental health). Pregnant women who smoke qualify for the program and will receive intensive counseling. Medication requests for NRT will be addressed by the primary care provider.

PTM and the DTC's collaborated to shorten the WIC powerpoint presentation; the same information is presented, but is less clinical and more participatory. A module for pregnant women is included.

c. Plan for the Coming Year

PTM and MCH will collaborate with the Office of MaineCare Services to identify ways to increase tobacco cessation benefits to pregnant women who smoke (Resolve 34, To Remove Barriers to Smoking Cessation Treatment in Maine).

CTI will expand its Face-to-Face counseling throughout Maine's 8 Public Health Districts to allow more pregnant women, particularly in rural areas, access to tobacco treatment.

CTI launched an Enhanced Outreach Clinic pilot in 10 Federally Qualified Health Center's to implement system change for brief tobacco treatment interventions. A clinical outreach specialist will visit the same office 4 times to determine how to incorporate the changes so all patients receive brief interventions and follow up to tobacco cessation. Consistent use of fax referrals to the Maine Tobacco HelpLine will be emphasized.

PTM will use the results of the NERHRT white paper to develop new interventions and resources to address smoking during pregnancy.

Provider materials, specific to cessation treatment for pregnant women, will be developed for CTI clinical outreach trainings.

PTM will work to increase the number of pregnant women who smoke to utilize the Maine Tobacco HelpLine resources. PTM and CTI will train and encourage medical providers, hospital systems, and social service provider offices to use fax referrals to the MTHL. Face-to-Face pilots will address pregnant women who smoke in offices, and the Enhanced Outreach Clinic will help offices incorporate Public Service Guidelines, including those interventions for pregnant women. The use and impact of fax referrals to the MTHL will be evaluated.

The MTHL will incorporate sections of the American Legacy Foundation "Postpartum Protocol Script for Tobacco Quit-Line Counseling" into its script for use when working with pregnant women.

Evaluation of social provider presentations will determine how to expand the DTC's role to address pregnant women who smoke throughout Maine's Public Health Districts.

PTM will work with hospitals to encourage increased use of fax referrals directly to the MTHL

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	11	10	9.9	9.2	8.3
Annual Indicator	11.3	9.3	8.4	10.0	10
Numerator	52	43	39	46	
Denominator	459295	463598	463424	460864	
Data Source					Death certificates, Maine Vital Statistics Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9	8.9	8.8	8.7	8.6

Notes - 2008
2008 mortality data are not yet available. The 2007 indicator is used as an estimate.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics

Notes - 2007
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from the Maine Office of Data, Research and Vital Statistics.

Notes - 2006
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

The 2006 indicator is the 5-year average for 2002-2006. Due to the small number of suicides, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation

a. Last Year's Accomplishments
Maine's suicide rate has fluctuated over the past several years. It appeared to be declining based on data from 2005 and 2006. The 5-year average suicide rate for 2002-2006 was 8.4 per 100,000 youth age 15-19, the lowest 5-year suicide rate we have seen in the past 15 years. However, preliminary 2007 data reveal an increase. The 5-year rate for 2003-2007 increased to 10.0 per 100,000. There were 13 suicides among youth age 15-19 in Maine in 2007. This rate exceeds our 2008 objective of 8.3 per 100,000. However, analyses of Maine's 2007 Youth Risk Behavior Survey data demonstrated a decrease in suicide ideation and attempts among Maine high school and middle school student, suggesting that our work is making a difference.

The Maine Youth Suicide Prevention School Protocol Guidelines were updated in FY08. New additions included a resource/fact sheet, a sample parental notification letter, flow charts for schools (intervention and postvention) and new information on warning signs. We also were successful in having our Protocol Guidelines reviewed and added to the Suicide Prevention Resource Center's Best Practice Registry.
The Maine Youth Suicide Prevention Program (MYSPP) web site was updated to include a survey to gain additional feedback from youth and adults. On average, the site received over 1000 hits/month. A middle school lesson based on the MYSPP youth web site was also created. A new youth suicide PSA was produced "in-kind" by a media partner and aired on television between May 6 and June 29, 2008.

A committee was convened to develop transition lessons for high school seniors and to develop an accompanying resource guide. Maine Department of Education (DOE) collaborated with MYSPP in providing Lifelines student lesson trainings to teachers.

143 individuals attended the 4th annual Beyond the Basics conference. Speakers included Dr.

Thomas Joiner, Dr. Barent Walsh, and Dr. Ken Minkoff. Suicide prevention training programs were conducted with 5 colleges: Universities of Maine, Southern Maine, and Farmington, Maine College of Art and Unity College.

59 training programs were offered to 1,493 participants during FY08.

The MYSPP Director received the 2008 Alex Kelter Vision Award for leadership and vision in the field of injury prevention in Maine.

The DOE annual Comprehensive School Health Education (CSHE) Spring Workshop was held in May 2008. 130 elementary and middle school teachers, high school health education teachers, administrators and school health coordinators attended. Injury prevention round table sessions included understanding deliberate self-harm, cyber bullying, school resources on depression in youth, and poison prevention.

The CSHE Program continued to promote a coordinated approach to create and ensure healthy and safe schools through 8 core elements. (Copy attached)

In June 2008, DOE held its' annual Maine Schoolsite Health Promotion Conference. 35 school systems participated for a total of 235 attendees. Sessions offered specific to injury included: stress/anxiety relief, cyber bullying prevention, and our keynote presentation; creative anger management techniques.

DOE health education staff coordinated the Health Education Resource Collection which provided educational materials on a variety of health related topics including injury prevention to health educators statewide.

Analyses were conducted on Maine's 2007 Youth Risk Behavior Survey (YRBS) data on correlates of suicide ideation and suicide attempts among youth. These analyses were consistent with the current literature and showed that suicidal behaviors were correlated with poor school performance, substance use, aggression, and depression. Victimization by peers, especially multiple victimization experiences, were also shown to be highly correlated with suicidal behaviors. Results were presented at the Maternal and Child Health (MCH) Epidemiology conference in December 2007 and presented to the MYSPP steering committee and the SAMHSA Suicide Prevention Grantee school coordinators.

Additional YRBS data analyses highlighted the significant overlap between self-injury and suicide and revealed that adolescents who engaged in suicide ideation as well as non-suicidal self-injury were more likely to engage in risky behaviors. These analyses were presented at the MCH Epidemiology conference in December 2007 and at the Council of State and Territorial Epidemiologists conference in June 2008.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate statewide access to crisis assistance and suicide prevention resources through promotion of statewide hotline and website			X	
2. Provide suicide prevention training and education programs statewide		X		X
3. Provide suicide prevention and intervention guidance and technical assistance to school and community personnel			X	X
4. Evaluate effectiveness of selected program components				X

5. Conduct surveillance of, analyze, interpret and disseminate reports on self-inflicted injuries and suicide among youth				X
6. Support implementation of CAL ME Project				X
7. Support implementation of plan goals, objectives, and activities as resources permit				X
8. Maintain and form new partnerships to effectively integrate youth suicide prevention activities in related programs and services				X
9. Work collaboratively to improve the quality and timeliness of self-injury data				X
10.				

b. Current Activities
MYSPP received a new 3-year federal grant, Caring About Lives in Maine (CAL ME), to implement and evaluate best-practice suicide prevention programs in 11 high schools and their related communities. The initial SAMHSA funded project serving 6 high schools and high risk populations ended in February 2009.

In February 2009 MYSPP collaborated with key partners to hold a forum for media on safe reporting on suicide. 30 individuals from TV, radio and print media, editors and producers, family members who had lost someone to suicide, health, education and social services attended. Evaluations revealed everyone gained a better understanding of reporting guidelines and the impact of effective reporting on the public, particularly on family members of suicide victims.

An FY09 focus is outreach to older youth out of school. Materials were developed with homeless youth for statewide dissemination, to groups of youth at increased risk of suicidal behaviors, through such mechanisms as police and the justice system.

DOE collaborated with MYSPP to provide Lifelines student lesson trainings to teachers and participated in piloting Lifelines Transitions student lessons for high school seniors focusing on transitions students face when leaving high school.

We are working on a surveillance document with data on suicides among Maine youth, including trends over time. Fact sheets on youth suicide and non-suicidal self-injury were distributed at the 09 Beyond the Basics suicide prevention conference

c. Plan for the Coming Year
Our performance objectives for the coming years reflect the challenges of reducing the youth suicide rate and of monitoring trends given small numbers. We hope that 2007's suicide rate will not be reflective of an overall change in the trend and that the suicide rate and self-injury hospitalizations over time decrease in the coming years. We anticipate a continued downward trend in reported suicidal behaviors among middle and high school students. Due to the fluctuations in rates over time, we have decided not to change our original 2009-2012 objectives. Our 2009 objective is to reduce Maine's suicide youth (ages 15-19) rate to 8.6 per 100,000. However the limited reach of the program to Maine schools and communities, plus state cuts to mental health services, may impact Maine's ability to change our rates.

FY10 plan includes continuing to provide gatekeeper training sessions, training of trainers, Lifelines teacher training, training for youth partners, and an annual suicide prevention conference.

We will continue to promote the 24-hour crisis hotline statewide through distribution of materials, the program website, and in all education and training sessions; explore ways to better use technology in an effort to reach our audience; and monitor trends in suicide and self inflicted

injuries among the Maine population and distribute updated fact sheets and resource materials in a variety of formats including the web site.

In addition, we will continue to implement the CAL ME youth suicide prevention project and associated evaluation activities and produce reports describing progress achieved.

DOE will include a section specific to injury and violence prevention and mental health in its Linking Key Concepts to the Maine Health Education Standards document; a document that links key education and prevention concepts to the health education standards and performance indicators outlined in the 2007 Maine Learning Results.

DOE will expand professional development opportunities in health education for elementary teachers and target training for middle and high school health educators to be determined by School Health Profiles data and the Maine Integrated Youth Health Survey results.

DOE will continue to participate in programming with the MYSPP, Healthy Maine Partnerships, Maine Integrated Youth Health Survey, and CSHP.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80.5	81	81	81.5	82.2
Annual Indicator	80.8	80.5	81.1	82.1	81.8
Numerator	636	659	672	690	667
Denominator	787	819	829	840	815
Data Source					Birth certificates, Maine Vital Records Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82.3	82.4	82.5	82.6	82.7

Notes - 2008
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2008 indicator is the 5-year average for 2004-2008. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Data are from birth certificates and were provided by the Maine Office of Data, Research and Vital Statistics.

Notes - 2007
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2007 indicator is the 5-year average for 2003-2007. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

Notes - 2006
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

The 2006 indicator is the 5-year average for 2002-2006. Due to the small number of very low birthweight births, a 5-year moving average has been reported since 1998 in order to control for potential large year-to-year random variation.

a. Last Year's Accomplishments
In 2007, 82.1% of Maine's very low birth weight (VLBW) infants were born at specialized facilities. This rate has not changed significantly over the past 10 years. Based on data on this measure from MCHB's TVIS system, Maine ranks 23rd out of 50 states on this measure.

Maine has 2 Level III nurseries; Eastern Maine Medical Center in Bangor and Maine Medical Center in Portland, and 1 Level II nursery, Central Maine Medical Center in Lewiston. Given the geography of the state and the population distribution it is not reasonable to expect all VLBW infants will be delivered at Level III hospitals. The neonatal transport system remains an important and active factor in obtaining better outcomes for pre-term infants born in Maine.

The Division of Family Health continues to collaborate with the Perinatal Outreach Education and Consultation Program (POEC) at Maine Medical Center (MMC). The POEC provides education and consultation and assumes a leadership role in a variety of public health activities, including the establishment of the Maternal and Infant Mortality Review process. The POEC contributed to the quality of perinatal care in Maine by providing 51 formal education programs reaching 704 health care professionals during FY08. In addition, 9 transport conferences were held. Transport conferences provided an opportunity for education and consultation during the review of specific facility-selected cases. Overall, program attendees continued to be primarily registered nurses (n=357), although many physicians (n=239), and others (n=108) participated in the educational programs, including advanced practice nurses and home birth midwives. Highlights included topics such as perinatal substance abuse, domestic violence and prematurity. The POEC continued to provide basic and advanced skills in assessment, management and resuscitation for high risk pregnancies.

In CY05 Title V submitted a successful proposal to the Maine March of Dimes for a grant for a Maternal and Infant Mortality Review Initiative (MIMR). The overall goal of the initiative is to strengthen community and state resources and a wide array of systems and policies for women, infants, and families. MIMR is modeled after the National FIMR Program to learn how to prevent maternal, fetal, and infant deaths by considering the broad environmental, social, and economic context in which those deaths occur. During FY07 Administrative rules for MIMR were drafted. The full Review Panel was convened July 18, 2007. An update of available data was discussed and a review of an infant death was completed using a "mock" case as an introduction to the Panel process. Feedback was obtained on the process for use in developing Panel protocols.

MIMR rules drafted in FY07 went to public comment and were adopted in February 2008. Panel protocols, including confidentiality, case review, and maternal and family interview guidelines were drafted, reviewed by stakeholders and finalized in June 2008.

Title V leadership partnered with the March of Dimes to plan the October 2007 Prematurity Summit. Over 150 perinatal nurses, nurse midwives, physicians and substance abuse counselors attended the conference. The Prematurity Summit featured Milton Kotelchuck, PhD,

MPH, Chairman and Professor, MCH, Boston University, School of Public Health. His presentation addressed "Women's Health and Preconception Care between Pregnancies: The Development of Inter-natal Care Programs".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to perinatal care providers regarding high risk care and monitor trends in service delivery				X
2. Assure statewide access to perinatal and neonatal transport systems	X	X		
3. Partner in the Prematurity Prevention Campaign led by the MOD			X	X
4. Monitor health and safety of home births				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There is a perceived increase in the morbidity and mortality of babies being born at home. The Child Death and Serious Injury Committee (CDSIC) is looking at the rate of Maine home births to determine if it is higher than the expected national rate. CDSIC is meeting with hospital based care givers to learn about hospital standards and the expected rate of hospital birth complications; and with nurse midwives and consumers who have chosen to home birth to better understand why families choose homebirths and what homebirth providers consider to be a low risk; preparations made for emergency or urgent transfer of a mother and child; documentation of problems and informed consent. CDSIC is reviewing cases to identify the rate of complications of Maine home births to determine the rate of transfer from home birth midwife to hospital when appropriate, to assess level of risk in the home births where there has been an untoward outcome, and evaluate the system of care involved in emergency transfer from a certified professional midwife to health care facility.

The MIMR Panel met in February 2009 to review an infant death related to Severe Combined Immune Deficiency (SCID). The Panel discussed many aspects of the case, including statewide transport system, national newborn screening discussions related to SCID and availability of social and bereavement services in Maine. Active recruitment of cases will be delayed due to the vacancy of the Newborn Screening Coordinator position.

c. Plan for the Coming Year

Collaborations will continue with the Maine Medical Center Perinatal Outreach Education and Consultation Program. Issues of concern to healthcare providers are often presented to the POEC nurse educator for consultation and assistance with evaluation, education and improvement to achieve best practice standards. Transport Conferences reviewing clinical cases and other educational programs will be promoted in areas that have not requested such programs in the past, building new relationships and connections.

In addition, it has come to our attention that Maine's Medicaid Office (Office of MaineCare Services) has contracted with Schaller Anderson Medical Administrators Inc. to help reduce

costs. Schaller Anderson has a high risk pregnancy program to identify targeted care management intervention to women insured by MaineCare at high risk of developing complications during pregnancy. They have a goal of getting newly pregnant women into prenatal care as soon as possible and intervene to promote healthy birth outcomes. They provide educational materials to both high and low risk pregnant women each trimester. In the coming year, we will try to learn more about this program and examine the materials they distribute to determine whether they are teaching women about the signs of early labor. They also have a case management database that tracks members' perinatal information. Some of the measurements in this system include the VLBW rate in their population, NICU admission rate, and timeliness of prenatal care.

Future epidemiologic analyses will include an examination of home births and their outcomes in the state. There has been discussion of developing a sentinel surveillance system in the state for monitoring outcomes with home births. In addition, the Maine CDC director has requested that Maine's Title V program, in collaboration with the Office of Substance Abuse, examine available data on perinatal substance use to determine the areas of the state with the highest burden of this problem and the birth outcomes associated with it.

Continue to review cases of infant deaths through the MIMR panel; summarize the number of cases and findings of the CDSI Committee on home births in a letter to Dr. Dora Mills with recommendations to the Governor in October 2009; and engage the MIMR Panel to track outcomes of homebirths over the next 2 years.

Based on the trend of the past nine years, which has shown little change, we hope to make incremental improvements in this measure over the next five years. We anticipate that these changes will be possible through the work of the MIMR panel and ongoing epidemiologic analyses of this issue. In addition, the new regional public health infrastructure will allow us to focus our efforts to specific parts of the state where this is an issue. We plan to provide the personnel in these districts with data related to this measure as well as presenting it to perinatal nurse managers throughout the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	89	89	90	90	90
Annual Indicator	88.1	87.8	87.4	87.1	86.8
Numerator	12276	12392	12370	12295	11814
Denominator	13929	14111	14152	14110	13606
Data Source					Birth certificates, Maine Vital Records Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics. Data are from 2008.

Notes - 2007
Data source: Birth certificate data provided by the Maine Office of Data, Research and Vital Statistics

Notes - 2006
Data source: Maine Office of Data, Research and Vital Statistics

a. Last Year's Accomplishments
Between 1998 and 2007, there has not been a statistically significant change in the percent of women receiving prenatal care beginning in the first trimester. Each year about 88% of women in Maine receive prenatal care in the first trimester. In 2006, the most recent year with comparable US data, Maine ranked second in the U.S. in the percent of women receiving prenatal care in the first trimester (among those using the unrevised birth certificate). However, if we examine early prenatal care by race, among Non-Hispanic Whites, Maine ranked 19th out of the 32 states using the unrevised birth certificate and Maine had the fifth lowest rate of early prenatal care among Blacks. Efforts to increase early receipt of prenatal care are based in Maine's Home Visiting Program (HV), Public Health Nursing Program (PHN), and WIC Nutrition Program.

The Maine HV Program is available universally to any teen parent and first time family throughout the state. An effort is made to enroll women before they have given birth to help assure proper prenatal care and healthy pregnancies. During FY08 fourteen agencies in 16 counties provided 21,586 home visits to families, a 5% increase in home visiting services from FY07. 4,958 families were served in FY08, with 2,846 receiving home visits. 36% were enrolled in the home visiting program prenatally. Parents reported that their participation resulted in positive changes in many areas, for example; home safety and child nutrition (98%), car safety (95%), breastfeeding (87%) and exposure to second hand smoke (89%). In FY08, using the Kotelchuck Index to measure adequacy or prenatal care, participants in the HV Program reached 91%

Maine's HV Program focused on using data to inform quality improvement during the reporting period. The HV Program provided technical assistance to sites on ways to enroll families earlier.

Standards of Practice for home visiting programs were further refined to provide more detailed guidance to programs. Topics included skills training, supervision, caseload, and collaboration. The standards were added as a contractual performance expectation for the 14 agencies providing services. A copy of the standards will be made available via the web with the redesign of the home visiting website.

It is a challenge for public health nursing to see individuals prenatally. A relatively small proportion of PHN visits (2.3% of all visits for PHN and 3.03% for CHN) are for prenatal care as an identified health need is required for referral. PHN outreach consisted of providing hospitals with information of services provided and location of district offices. The primary referral source for home visiting is hospitals through childbirth classes and this is usually in the last trimester. OBGYN's generally only refer if the mother is considered at risk. There has been no significant increase in prenatal referrals.

The WIC Nutrition Program is collaborating with the PHN staff and other partners to enhance the provision of services to pregnant women in their first trimester. The WIC Program increased its outreach through conference presentations and exhibits in an effort to increase enrollment.

Although WIC did not see a significant change in enrollment they continued to provide outreach.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Home Visiting Programs with reciprocal referral, PHN/CHN identifying health needs, Healthy Families identifying non-medical family support and parent education services	X			X
2. Provide technical assistance to providers of parent education and support services related to implementation and maintenance of parent education and support services				X
3. Enhance collaboration with the local WIC agencies, PHN and other partners to enhance access to services for pregnant women		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data from 2008 births in Maine reveal that 87% of new mothers received prenatal care in the 1st trimester. This is the same rate as 2006 and 2007. In FY09, we completed in-depth analyses of prenatal care utilization using birth certificate data. Based on these analyses, we found that early prenatal care varied by region, race, age and education. A brief report on these analyses is being developed.

For FY09, it became a contractual expectation that the HV contracted sites increase their prenatal enrollment to 50%. This has resulted in increased efforts to engage prenatal clients.

In early FY09 the state's MaineCare Program contracted with a Medical Administrator (MA) to provide case management to pregnant MaineCare members identified to be at high risk in an effort to improve health outcomes. The case manager works with enrollees to ensure they make regular visits with their provider and receive early referral to high risk providers in an effort to prevent NICU days. The PHN Program will work with the contractor on referrals to conduct long-term assessments. The MA began referring any interested eligible prenatal MaineCare member to the HV Program mid-FY09.

c. Plan for the Coming Year

Maine's objective for this measure is that the percent of women receiving prenatal care in the first trimester reach 90%. This is the same as the HP2010 goal and the Healthy Maine 2010 for this objective.

This data will help inform outreach efforts for the HV programs that collectively are developing strategies to engage Family Planning and health care clinics for earlier prenatal referrals. In addition, the curriculum used for prenatal enrollments, which requires a specific skill set for engaging parents before the child is born, is being reviewed and updated and will become part of the core knowledge expectations of home visiting professional development.

The WIC Program will continue to focus on outreach efforts to increase the number of WIC women enrolled in the first trimester of pregnancy. With the pending food package changes the state agency staff will be traveling around the state to train local agency staff on the changes. In FY09 one of the indicators for the local WIC agencies was to increase the number of WIC women enrolled in the first trimester of pregnancy. The Program will continue to collaborate with the local WIC agencies, PHN and other partners to enhance access to services for pregnant women.

The HV Program's ability to track first trimester enrollees will improve with the development, during FY09, of a new web-based database. After launch, we anticipate being able to determine which sites are receiving the earliest referrals and from which sources.

The HV and WIC Programs will work together to explore ways to market services and create referral strategies that result in earlier referrals to each other's programs.

WIC will also work with the Perinatal Nurse Managers to increase outreach.

D. State Performance Measures

State Performance Measure 1: *The percentage of births in women less than 24 years of age that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	57%	58	46	45	44
Annual Indicator	46.9	54.1	59.2	56.8	56.8
Numerator					
Denominator					
Data Source					Maine PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	43	42	41	40	39

Notes - 2008
2008 PRAMS data are not yet available; 2007 were used as an estimate.

Notes - 2007
The data source for this measure is the 2007 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

Notes - 2006
The data source for this measure is the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are weighted, therefore the numerator and denominator for this measure are not entered.

Please note that the estimate for 2003 was changed from 59.2 to 50.7 when it was discovered that previous data had been provided for women less than 25 years of age instead of 24 years of age. The 2003 and 2004 data reflect unintended pregnancies among those under age 24. We could not change the values prior to 2003.

a. Last Year's Accomplishments

According to the most recent data from Maine's Pregnancy Risk Assessment Monitoring System (PRAMS), over half (56.8%) of births to women less than 24 years of age in Maine were unintended. Unintended pregnancy in Maine is most common among young women, women with less than a high school education, and low-income women. It is especially difficult to attempt to reduce unintended pregnancies among women age 20-24 who are no longer in school; over half of these pregnancies are unintended.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Clinical Services	X			
2. Community-based pregnancy prevention and family planning outreach		X	X	X
3. Continue to monitor via PRAMS				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Despite the lack of new resources, reductions in existing resources and continued success of current strategies, the TYAH Program continues to examine our strategies and compare them to the growing research base on effective practices. Because of the greater consequences for younger pregnant and parenting teens, and the importance of early knowledge and skill development that carries into young adulthood, the majority of unintended pregnancy prevention resources continue to focus on school-aged youth. However, without eliminating this focus, we are increasing outreach and clinical efforts to reach young adults, as well as working with young adults in minority communities.

The TYAH Director sits on a new council, Shared Youth Vision Council, convened by the Children's Cabinet to look at coordinating efforts around transition for disconnected youth. Their focus will be on social service support systems rather than on the more traditional economic and education systems.

We are currently completing analysis of unintended pregnancies to gain more insight into the correlates of the problem in the state. Preliminary analyses reveal that unintended pregnancy is associated with low educational status, low income, and Medicaid enrollment prior to pregnancy. Additional analyses will focus on the relationship between unintended pregnancy and prenatal maternal health habits and birth outcomes. Results of these analyses will be presented in a report that will be available to the public.

c. Plan for the Coming Year

Maine's objectives for this measure through 2011 anticipate a decline in this measure over time. We hope that the recent trend we have seen in the percent of unintended pregnancies in this age group will change direction. However, we acknowledge that proposed budget cuts to family planning services may challenge our ability to change the direction of this measure.

The basic infrastructure of the program will remain in place, however funding reductions and increased health care costs preclude any increases in services and will continue to challenge our

ability to maintain current levels of services.

State Performance Measure 2: *The percentage of 0-11 month old children enrolled in WIC who were ever breastfed.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			55	56	57
Annual Indicator	53.8	58.2	55.9	55.9	55.9
Numerator	5813				
Denominator	10804				
Data Source					Maine PedNSS data
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	58	59	60	61	61

Notes - 2008
The source for this data are 2005 PedNSS data. Maine's current datasystem is unable to provide data for this measure at this time. However, the WIC program will have a new datasystem in summer 2010 that will be able to provide data to inform this measure.

Notes - 2007
2007 PedNSS data are not yet available; 2006 data were used as an estimate.

Notes - 2006
Data are from 2006 PedNSS.

a. Last Year's Accomplishments
The Maine WIC Nutrition Program has two performance based contracting goals for the local grantee agencies. One goal is to increase the percentage of infants born to WIC mothers who were, at one time, exclusively breastfed based on the number of exclusively breastfed infants born to WIC mothers in the previous year. Unfortunately, the WIC Program experienced problems with the accuracy of the breastfeeding goal data as a result of changes to the data software during CY08. WIC's new data system is currently undergoing revisions to the system and the new database will be operational in summer 2010. The WIC program is unable to provide recent breastfeeding data at this time.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to work toward the development of an efficient data system for collection of WIC breastfeeding data				X
2. Provide technical assistance to local WIC agencies to increase breastfeeding rates and duration				X
3. Continue to provide training opportunities for WIC counselors on the development of counseling and clinical skills to support optimal breastfeeding practices				X
4. Evaluate VENA training provided to local agency WIC staff				X
5. Implement and evaluate indicators to achieve the WIC Goals				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to the most recent data available from the Maine WIC Nutrition Program, in CY2006 56% of WIC infants were ever breastfed and 23% were breastfed at six months. The WIC database is currently in the process of revision. We hope that with these revisions, the breastfeeding data from WIC participants will become more reliable and we will have more information on breastfeeding duration among WIC participants.

The Maine State Breastfeeding Coalition, Maine Lactation Consultant Association and WIC Program collaborated on the annual breastfeeding education conference for health care professionals. The title of the May 2009 conference was "Supporting the Nature of Breastfeeding". 75% of local agency staff attended. The conference provided an opportunity for local WIC agency staff to learn current evidence based breastfeeding practices that can be applied when counseling participants.

c. Plan for the Coming Year
Work with home visitors to improve breastfeeding rates.

Continue to provide technical assistance to local WIC grantee agencies in meeting the WIC breastfeeding performance goal.

State Performance Measure 3: *The motor vehicle death rate per 100,000 among children 15 to 21 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	26	28	26	25	24
Annual Indicator	26.6	27.1	27.6	26.7	26.7
Numerator	168	174	178	170	
Denominator	630463	641315	644640	636635	
Data Source					Maine Vital Records Files
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23	22	21	20	20

Notes - 2008
2008 mortality data are not yet available; 2003-2007 data were used as an estimate.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rates for 15-21 years olds are:

2003-2007: 162/626635=25.4

Notes - 2007
The motor vehicle death rate per 100,000 among children 15 to 21 years of age. The number of motor vehicle deaths is a 5 year average of 2003-2007.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rates for 15-21 years olds are:

2003-2007: 162/626635=25.4

Notes - 2006
The motor vehicle death rate per 100,000 among children 15 to 21 years of age. The number of motor vehicle deaths is a 5 year average of 2002-2006.

This indicator is based on ICD-9 codes E810-E825.

Please note that the HP2010 indicator only includes codes: E810-E819. Based on this definition, Maine's 5-year average motor vehicle death rates for 15-21 years olds are:

1998-2002: 187/610243 = 30.6
1999-2003: 174/619849= 28.1
2000-2004: 164/630463= 26.0
2001-2005: 169/641315 = 26.4
2002-2006: 168/644640=26.1

a. Last Year's Accomplishments
Maine's 5-year average motor vehicle death rate among youth 15-21 years in 2003-2007 was 26.7 per 100,000. This is very similar to Maine's 2002-2006 rate of 27.6 per 100.000 and translates into about 34 deaths per year. In Maine, due to the small population size, we tend to present 5-year averages for many rates to help stabilize estimates over time. However if we examine single year deaths rates, we see that in 2003, Maine's single year motor vehicle death rate for youth age 15-21 was the lowest it had been in 15 years at 19.3 per 100,000. Since then it has climbed and in 2006, it reached a rate of 32.6 per 100,000, the highest it has been since 2001. In 2007, it again decreased to 24.5, so we need to wait and see what happens in the future. The rate of death among 20-21 year olds is generally slightly higher than 15-19 year olds, but there is not a significant difference between the two age groups. Based on this data, motor vehicle crash deaths and injuries are a priority area in the Maine Injury Prevention Program (MIPP) plan.

In order to attempt to decrease the motor vehicle death rate in the state, the MIPP actively participated to seek passage of a mandatory seat belt law (L.D. 24) by providing data, and testimony. The bill allows a police officer to detain and cite a vehicle operator or passenger 18 years of age or older solely for failing to wear a seat belt. The law went into effect September of 2007. According to 2007 Youth Risk Behavior Survey (YRBS) about 77% of high school students in Maine always or most of the time wear a seat belt when driving in a car with another person. We will continue to track seatbelt use among adolescents using Maine's Integrated Youth Health Survey.

L.D. 161, "An Act to Prohibit the Use of Cellular Telephones by Minors While Driving" was passed and signed by the Governor on June 11, 2007 and went into effect in September 2007. This bill prohibits a person who has not attained the age of 18 from using a cellular telephone while operating a motor vehicle. The bill makes the offense a traffic infraction. We are hopeful these

efforts will further enhance the safety of Maine youth.

The MIPP provided technical assistance to the Maine Transportation Safety Coalition and other state and public agencies to develop instruments to evaluate Maine's "Get Out Alive" Challenge for young drivers. The program provides classroom education, an interactive website, a teen newsletter and culminates in a driving challenge for teens and their parents.

The Department of Education (DOE), Health Education and Health Promotion Program promoted, through exhibits, driving safety and seat belt safety at their Annual Schoolsite Health Promotion Conference in June 2008. Two Hundred Thirty-five attended from 35 school systems. They also promoted bicycle and walking safety and encouraged participants to incorporate in the school health education curriculum. In addition, those schools with a Resource Officer (local police officer), offered classes to high school students on motor vehicle laws and the impact of the laws.

The DOE held its annual Comprehensive School Health Education Workshop in May 2008. 130 elementary and middle school teachers, high school health education teachers, administrators and school health coordinators attended. Resources and information were provided around Maine's Health Education Standards and the Health Education Resource Collection which provided educators materials on a variety of health related topics including motor vehicle safety.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop resource materials on young driver safety		X		X
2. Work with Bureau of Highway Safety on a CPS Observational Study				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through its CDC Surveillance Grant, the Maine Injury Prevention Program (MIPP) is sponsoring efforts of the Safety and Health Council of Northern New England and the town of Windham in their application to be designated a Safe Community by the National Safety Council. A goal of this effort is to foster local injury prevention partnerships and increase community awareness about injury and violence prevention through the use of community specific injury data. The application was submitted in June.

MIPP is evaluating Maine's "Alive@25" Program, designed to provide education and awareness to teen drivers and their parents. Results will be reported in FY10.

A teen driver symposium was held in June 2009. Education representatives, health care, law enforcement, state and federal transportation agencies, public and private agencies such as AAA, and driver education groups attended. Kim Hazelton, educator at Bristol Eastern High School in CT presented their school's work on implementing the "Teens in the Driver Seat" Program. Analyses of Maine's Fatal Accident Reporting System were conducted to inform this symposium. Analyses revealed 117 deaths to teens age 15-19 in Maine between 2003-2007. Of these, 58% involved a teen driver and another 29% involved the death of a teen passenger at the hands of a

teen driver. Outcomes of the day included identifying strategies and initial steps to implement an effective teen driver intervention program in Maine.

c. Plan for the Coming Year
Given recent legislative initiatives, we anticipate that Maine's motor vehicle death rate will decrease over the next few years.

During FY10, MIPP staff will continue to:

1. Provide training and information to advocates on safe driving and the importance of buckling up.
2. Maintain the MIPP web site to disseminate prevention resources, contacts, data, training opportunities, and
   links to other Maine and national injury prevention resources.
3. Collaborate and coordinate with the Maine Transportation Safety Coalition and other committees, and state
   agencies to protect Maine's young drivers.
4. Upon request disseminate current data through MIPP fact sheets.
5. Identify community partners with whom to conduct a teen driver safety intervention to be evaluated.

DOE will hold its annual Comprehensive School Health Education workshop in 2010 for health education and classroom teachers. Injury prevention and safety topics will be included.

DOE will expand professional development opportunities in health education for elementary teachers as well as targeted training for middle and high school health educators to be determined by School Health Profiles data and the Maine Integrated Youth Health Survey results.

State Performance Measure 4: *The percentage of high school students (grades 9-12) who are overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			10.5	10.5	12.8
Annual Indicator	12.8	10.9	10.9	12.8	12.8
Numerator					
Denominator					
Data Source					Maine YRBS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	9.5	9.5	9

Notes - 2008
Data are from the 2007 YRBS. The data are weighted, therefore a numerator and denominator are not entered for this indicator.

In 2009, Maine administered the Maine Integrated Youth Health Survey. Data from this survey will be available in summer 2009 and will inform this measure in future years.

Notes - 2007

Data are from the 2007 YRBS. The data are weighted, therefore a numerator and denominator are not entered for this indicator

Notes - 2006
Data from YRBS are weighted therefore a numerator and denominator are not entered for this indicator.

The indicator for 2006 is the same as 2005 because the YRBS is administered every other year. The next survey will be administered in 2007 and data should be available in 2008.

a. Last Year's Accomplishments
Maine uses data from its Youth Risk Behavior Survey (YRBS) to track this measure. These data reveal that the percent of overweight and obese high school and middle school students in Maine has not changed significantly between 2001 and 2007. The most recent YRBS data from 2007 indicate that 13.1% of high school students are overweight (85th-95th percentile of BMI) and 12.8% are obese (>95th percentile). Therefore, more than 1 in 4 Maine adolescents are above a healthy weight. Maine's percent of overweight youth in 2007 is statistically lower than the 2007 U.S. percent, but there is no difference between the U.S. and Maine in the percent of youth who are obese. The Healthy People 2010 goal for adolescents age 12-19 is 11%.

The Physicians in Schools Initiative is a private/public partnership that began in 2004 to promote cooperation between physicians and schools to improve student health and academic success through a coordinated approach to school health. In FY07 the focus shifted to obesity and the schools role in addressing the problem. The Physical Activity and Nutrition Program Manager assumed a co-lead responsibility in working with this group of physician organizations, Maine DHHS, the Maine Department of Education (DOE), American Academy of Pediatrics, Maine Chapter, and the Maine Academy of Family Physicians. During FY08 the group began review of and piloting a power point presentation designed for school superintendents and physicians. Once completed the presentation will be used for community and school leadership groups at the local level in an effort to address overweight.

School based Health Centers (SBHC) are addressing nutrition and physical inactivity. The centers are asked to do a health risk assessment of any student enrolled in the center and that visits the center for a service. Based on the assessment results some referrals are made to the in-school fitness center. The SBHC's are asked to follow up to determine if there is a behavior change. During FY08 495 students were identified as being physically inactive and of those approximately 138 (28%) received some counseling to develop a plan to be more physically active. Of those who received an intervention 13% showed improvement. During the same period 324 students were identified with poor nutrition. Of those identified 270 or 83% received an intervention with 22 showing improvement.

The "Let's Go! Takes 5-2-1-0 to School Initiative" a component of the private sector Let's Go! Campaign was made available to 12 southern Maine communities during FY07. The primary goal of the initiative is to increase PA and healthy eating amongst children and youth up to age 18. The initiative addresses policies, environments, and practices that influence the following health behaviors in the school setting; eating 5 fruits and vegetables per day, limiting screen time to 2 hours per day, engaging in 1 hour of physical activity per day, and increasing water consumption as well as low fat milk while limiting sugar sweetened beverages. The pilot resulted in 196 of 280 schools statewide implementing wellness policies on physical activity and nutrition.

The DOE Health Education Consultants worked with health education teachers, physical education teachers, elementary classroom teachers, curriculum coordinators, school health coordinators, and school nurses to ensure physical activity, fitness, and nutrition education were incorporated in the health education curriculum across all grade levels in alignment with the 2007 Maine Learning Results Health Education Standards.

DOE's Annual Comprehensive School Health Education Spring Workshop was held in May 2008. Nutrition and healthy eating education round table sessions included such topics as Maine Dairy and Nutrition Council resources for schools and the Health Education Resource Collection. The keynote presentation was by the Alliance for a Healthier Generation whose mission is obesity prevention. Six of the concurrent sessions included presentations promoting healthy eating and obesity prevention knowledge and skills.

The June 2008 Annual Maine Schoolsite Health Promotion Conference offered sessions specific to nutrition education and obesity prevention that included 2 keynote presentations; one on schools and obesity prevention; the second on the role of food service in motivating change. Nutrition and physical activity were the focus of 11 organizations exhibits, 9 round table discussions, and 9 concurrent sessions.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to achieve the Healthy People 2010 nutrition/physical activity and fitness objectives			X	X
2. Enhance Maine's nutrition and physical activity surveillance infrastructure				X
3. Continue monitoring trends in overweight through the Maine Integrated Youth Health Survey			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

An exciting partnership pilot program between a major grocery chain (Hannaford) and a southern Maine middle and high school to rate prepared meals, snacks, salad bar and grab-and-go items according to their nutritional value began in early 2009. This science-based program was the first of its kind when implemented in select grocery stores in 2006 in response to consumer demand for a simple, easy-to-understand tool for making good nutritional choices as they shop. The rating system credits all edible foods based on the presence of vitamins, minerals, dietary fiber and whole grains, and debits for the presence of trans fat, saturated fats, cholesterol, added sugars and added sodium. Food items are awarded zero, one, two or three stars -- one star means good nutritional value; two stars, better nutritional value; and three stars, best nutritional value. The program gives students more information to easily identify the foods with the greatest nutritional value and make healthy food choices. Another benefit is the consistency of seeing Guiding Stars both in school and the grocery store. Students and their families can talk about nutritious food choices based on information that is accurate and easy to use and understand. If successful, Hannaford will work with other schools.

c. Plan for the Coming Year

Although the rates of obesity and overweight in Maine have not increased significantly over the past few years, the high rates point to a need to address the issue before the health consequences of excess weight cause lasting problems. Starting in 2009, we will have data on this indicator from the Maine Integrated Youth Health Survey. Maine hopes to see gradual declines in the rate of adolescent obesity over the next five years, although we acknowledge that

it is challenging to see changes in this outcome on a short-term basis even if our efforts are making a difference.

The PANP will collaborate with the DOE to consider further modifications of food guidelines for school lunch programs.

The Coordinated School Health Program (CSHP), in its new federal CDC workplan, will work to raise funds to provide mini grants to add new sites for coordinated school health. CSHP plans to look at low performing schools and schools most likely to have higher obesity rates and high risk behaviors. Up to 5 new priority schools will be identified by health risk behavior.

SBHC's will continue to work with enrolled students to develop physical activity and nutrition plans.

DOE will expand professional development opportunities in health education to elementary teachers, as well as, targeted training for middle and high school educators to be determined by School Health Profiles data and the Maine Integrated Youth Health Survey conducted in the Spring 2009.

DOE will continue development of the High School Wellness Portfolio project with health education teachers, physical education teachers, and school health coordinators started in April 2009. The group is tasked with developing wellness portfolios for students to achieve health education and physical education standards as part of high school graduation requirements. All high school students will be required to have health education and physical education course work. When students are not enrolled in a health education or physical education class they will have to establish a personal fitness and personal health goal for the year that they must work on throughout the year.

State Performance Measure 5: *The percentage of high school students (grades 9-12) who feel like they matter to people in their community.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			57	60	57.3
Annual Indicator		57	57	57.3	57.3
Numerator					
Denominator					
Data Source					Maine YRBS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	63	65	65	66

Notes - 2008
The data used for this measure come from the 2007 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator.

In Spring 2009, Maine administered the Maine Integrated Youth Health Survey. Data from this survey will be available in summer 2009 and will inform this measure in future years.

Notes - 2007
The data used for this measure come from the 2007 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator

Notes - 2006
The data used for this measure come from the 2005 YRBS. The data are weighted therefore a numerator and denominator are not presented for this indicator.

The 2006 percentage is the same as 2005 because the YRBS is administered every other year. The next survey will be administered in 2007 and data should be available in 2008.

a. Last Year's Accomplishments
This measure was selected based on our desire to look at strengths and not just deficits. It is based on positive youth development theories regarding the relationship between increased youth assets and decreased risk behavior. Vermont has monitored 5 assets of youth strength for several years and using this indicator moved us toward a shared regional measure. The question was first asked in Maine in the 2005 Youth Risk Behavior Survey (YRBS). In 2005, 57% of adolescents reported that they felt like they mattered to people in their community. In 2007, the percentage remained at 57.3%. Boys were slightly more likely than girls to positively respond to this question (60.4% vs. 54.4%). There were no differences by age or grade level on this measure. This measure and other asset-based measures for youth were included in the Maine Integrated Youth Health Survey. This survey, which combines Maine's YRBS, Youth Drug and Alcohol Use Survey, and Youth Tobacco Survey was developed over several years. The final draft of the survey was completed in FY08. Data will be available in FY10 allowing us to continue to track this measure.

Active youth involvement in public health efforts recognizes the value of youth. In addition to informing state programs about youth concerns directly, this demonstrates our commitment to youth inclusion to our community partners.

The 24th annual Peer Leadership Conference titled Maine Youth Leading the Way was held in November 2007. 510 youth and adults attended. Workshops featured leadership and teen health topics such as: youth activism and policy change, youth and adult partnerships, action planning, anti-tobacco, physical activity and nutrition, facilitation skills, diversity awareness, substance abuse, youth suicide prevention, dating violence, and bullying prevention. 61 youth presenters co-facilitated workshops. 4,603 individual resources were distributed at the conference. As a result of the conference, 99% of the youth planning team said they felt more prepared to partner effectively with adults, 87% said they gained information skills and resources needed to create positive change in their communities, and 97% felt more prepared to create positive change in their communities.

The 4th annual Stop, Quit, Resist Youth Tobacco Summit brought together youth and adults for skill building, networking and information sharing around anti-tobacco advocacy. 232 attended including 177 youth and 55 adults. 10 youth from across the state were involved in planning and implementing all aspects of the summit. 94 Youth Advocacy Project (YAP) members were in attendance. 98% of attendees reported that as a result of their participation they felt more prepared to create positive change within their school and/or community.

A state team participated in the Spotlight in Positive Youth Development, an Initiative funded by the federal CDC, and facilitated by the Cooperative Extension 4-H Program at the University of Arizona. This 1 year project involved training teams of 4 adults and 2 youth followed by monthly web casts and further trainings for communities interested in promoting youth adult partnerships. The team attended a youth development training in Maryland in February 2008, which included positive youth development concepts, visioning, partnership development and action planning.

The Teen and Young Adult Health Program has supported MYAN's partnership with the Maine Assembly of School-based health Centers to develop youth advisory committees in SBHCs funded by the State. In addition to providing input to local school policies and peer education programs, youth mobilized for Legislative Day. Youth provided testimony in front of the Health and Human Services Legislative Committee in support of increasing funds for SBHCs. We

believe that the strong testimony provided by the youth contributed to the legislators' decision to increase funding for school-based health centers in Maine.

YAP groups within the Healthy Maine Partnerships (HMP) worked on policy and environmental changes in their communities to reduce access to tobacco and second-hand smoke, increase physical activity and improve nutrition. MYAN worked with YAPs to create action plans and better integrate with the core activities of the HMPs. MaineCDC staff worked with MYAN to develop a resource guide and provide guidance on expectations for HMPs regarding youth involvement and ensure youth involvement was included in HMP data collection.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Youth involvement and leadership technical support, training, and networking				X
2. Coordination and collaboration in youth-related initiatives				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MYAN is expanding its training offerings with new youth/adult partnership regional trainings. The one-day sessions that include both youth and adults, trainers and participants provide skills on how to work together so that community health initiatives can positively involve youth in healthy changes in schools and communities.

The MYAN contract was re-bid and re-issued to People's Regional Opportunity Program (PROP) in Portland for another 5-years.

Maine's Integrated Youth Health Survey was administered in February of 2009. 80% of middle and high schools participated. This survey will provide information on this measure as well as other asset-based measures of health. The other asset based measures include: having support from teachers, talking with parents about school, spending time in clubs or other organizations outside of school, and involvement in community service. One advantage of the Maine Integrated Youth Health Survey over the Maine Youth Risk Behavior Survey is that data on these questions will be available at the school-level. Therefore, schools and communities will directly receive data on how they are working to increase adolescent assets.

c. Plan for the Coming Year

For 2011, Maine's Annual Performance Objective for this measure is 65%. This may be ambitious given the lack of change in this measure between 2005 and 2007, but the integrated survey will provide local level data on this measure. This will allow specific schools and communities to examine the data from their students and work at the local level to improve adolescents' relationships with their communities.

Data on this indicator will continue to be collected as part of Maine's 2009 Integrated Youth

Health Survey.

The annual peer leadership conference, youth anti-tobacco summit, youth-adult partnership training, technical assistance, and networking will all continue as part of the new contract requirements.

The State's participation in the Spotlight in Positive Youth Development will continue, bringing together our Communities for Children and Youth Initiative, the HIV Prevention Education Program at the Maine Department of Education, and the Teen and Young Adult Health Program for further training and shared understanding of positive youth development. Other activities include developing an Executive Branch Youth Advisory Council using Colorado as a potential model.

TYAH Program will also determine mechanisms to include youth input in the comprehensive strengths and needs assessment.

State Performance Measure 6: *The percentage of elementary schools that have developed and implemented a comprehensive approach to the prevention of bullying in collaboration with the Maine Injury Prevention Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			8	9	10
Annual Indicator	6.3	7.2	7.2	5.3	5.3
Numerator	34	40	40	29	29
Denominator	539	559	556	545	545
Data Source					Maine Injury Prevention Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	12	12	12	12

Notes - 2008
Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2007-2008 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The number of schools that received a comprehesive bullying prevention program was incorrectly reported in prior years. To date, the Maine Injury Prevention Program has worked with 29 schools to implement a comprehensive bullying prevention program. New training institutes have trained additional school personnel to implement the program, but MIPP has no way of following up with the personnel to determine if the program has been implemented.

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

Notes - 2007

Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2006-2007 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The number of schools that received a comprehesive bullying prevention program was incorrectly reported in prior years. To date, the Maine Injury Prevention Program has worked with 29 schools to implement a comprehensive bullying prevention program. New training institutes have trained additional school personnel to implement the program, but MIPP has no way of following up with the personnel to determine if the program has been implemented.

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

Notes - 2006
Data Sources:
Numerator: Maine Injury Prevention Program
Denominator: Number k-8 public schools in Maine, Maine Department of Education, 2005-2006 (According to Maine Statute, an Elementary school means that portion of a school that provides instruction in any combination of kindergarten through grade 8. Only public schools are included in the denominator).

The Maine Injury Prevention Program is currently exploring new ways to address bullying prevention in schools and has stopped implementing the bullying prevention curriculum in new schools. This performance measure will continue to be tracked, but will likely change in the new grant period.

a. Last Year's Accomplishments
The data reported for this measure are based on implementing the Maine Bullying Prevention Education Program (BPEP), coordinated by Maine Law and Civics Education (MLCE) at the University of Southern Maine through a Cooperative Agreement with the Maine Injury Prevention Program (MIPP).

29 schools in Maine have implemented bullying prevention programs through the MIPP.
The Peace Studies Program at the University of Maine (PS) and Maine Law and Civics Education at the University of Southern Maine (MLCE) collaborated on several initiatives during FY08 to support Maine schools in reducing youth violence, bullying and misbehavior, and in strengthening protective factors for students, through the implementation of restorative justice, bullying prevention education, school climate change and conflict resolution education.

PS and MLCE conducted a statewide School Climate Survey to gather data from educators on the kinds of school climate efforts underway around the state. 28 educators completed the surveys; all respondents had bullying prevention programs in their schools and over 70% indicated the programs were effective or very effective.

Bullying Prevention activities included providing training and support to school coordinators enabling them to lead program implementation and train others within their school systems. MLCE held a 5-day Bullying Prevention Training Institute for 18 educators from 9 Maine schools in April 2008.

In November 2007 PS and MLCE co-sponsored the first statewide conference introducing restorative justice to Maine educators: "Transforming Discipline: Building Community through

Restorative Practices." 32 Maine educators from 13 schools attended (along with others from 6 states and Canada). Participants learned about restorative practices from keynote speakers Belinda Hopkins and Judy Mullett. Attendees also experienced the Community Circles process and the World Café model. Evaluations were very positive for all aspects of the conference.

The "Transforming Discipline" Conference resulted in 18 Maine schools or school districts expressing interest in learning more about restorative practices and potentially partnering with PS and MLCE in implementing restorative practices in their schools. PS and MLCE subsequently conducted introductory presentations for 3 schools/districts. PS and the Restorative Justice Project of the Midcoast conducted a Restorative Conference at a Middle School, involving a student who had committed serious offenses and 10 adults who were connected with the student.

In June 2008, PS and MLCE contracted with a Junior High School (approximately 40 staff and 325 students) to collaborate on a 2-year initiative to implement restorative practices in a whole-school approach. PS and MLCE met with a steering committee to set the stage for further efforts in the 2008/09 school year.

PS conducted 3 half or full-day trainings in restorative practices, including relational literacy, the Community Circles process, the Community Resolution Circle process for student misbehaviors, and peer mediation, for 3 schools (with a combined student population of 1368). A total of 110 educators and 13 students were directly involved in the trainings. As a result of these trainings, 1 school proceeded to implement restorative discipline throughout the school and another established a peer mediation program. MLCE conducted a restorative justice workshop in January 2008 for 20 pre-service teachers at the University of Southern Maine who were interning at Portland area schools.

In April 2008 PS and MLCE co-sponsored a biennial Youth Mediators' Conference in Augusta, attended by 57 students and adults from 9 elementary, middle and high schools. The group participated in a Community Circles activity and students attended workshop sessions on listening skills; creating safe, respectful schools; stereotypes and prejudice; mediation practice; and sexual harassment. Adults shared concerns and networked in a coordinators' dialogue.

As part of its annual Comprehensive School Health Education Spring Conference, the Department of Education included a session on cyber bullying. It was well received by those in attendance.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct bullying prevention workshops for school coordinators				X
2. Provide guidance and technical assistance to school coordinators implementing comprehensive school-based bullying prevention programs				X
3. Develop online bullying prevention surveys to facilitate schools' assessment of bullying prevention strategies				X
4. Provide training, technical assistance and guidance to schools in restorative practices to reduce risk factors and enhance protective factors for at-risk students				X
5. Develop and administer student and staff surveys and reporting tools to assess the impact of restorative practices in the schools				X
6. Conduct regional workshops and a restorative practices				X

institute for Maine school administrators and educators				
7. Increase statewide awareness and understanding of restorative practices through publication of a semi-annual newsletter		X		X
8.				
9.				
10.				

b. Current Activities

PS and MLCE continue to work with pilot schools implementing school-wide restorative practices. PS and MLCE provided 4 workshops in restorative practices to 40 Jr. High School staff between August 2008 and March 2009. We are meeting regularly with the steering committee to facilitate their leadership role in implementing restorative practices. Another Jr. High School has been added as a pilot school and PS met with the administrative team and conducted an introductory workshop for 50 staff in January 2009. The next step is to work with their steering committee on its leadership role in the program and to provide additional staff training and technical assistance.

MLCE conducted an advanced bullying prevention workshop for 15 educators from 7 schools or school districts in October 2008. The focus was on integrating restorative practices into bullying prevention programs.

PS, MLCE, and MIPP collaborated on developing online student and staff surveys as part of the evaluation of the restorative practices approach. The surveys are being administered in the 2 pilot schools.

c. Plan for the Coming Year

Although the MIPP anticipates that the number of elementary schools that have a comprehensive bullying prevention program will increase, we are unable to track this measure in a definitive manner. However, given the importance of this issue, additional data sources to program evaluation are being explored that contain information on bullying experiences that could be used to track this issue in future years. These sources include the Maine Child Health Survey and the Maine Integrated Youth Health Survey, both of which will be administered to students biennially through the schools.

The MCLE will continue the training workshops in bullying prevention, as this approach is the most cost-effective means of spreading bullying prevention implementation strategies throughout Maine elementary schools. MLCE will also assist schools by developing online bullying surveys for use in assessing their bullying prevention efforts.

MCLE and PS plan to implement restorative practices in up to four K-12 schools. This approach is currently being implemented in two schools with plans to add additional schools in FY10. Implementation has included developing evaluation tools, meeting with school administrators, establishing school leadership committees, providing staff training and development, and providing technical assistance in all phases of school-level implementation. One pilot school already has bullying prevention strategies in place. We will assess the impact of restorative practices on school climate through collection of disciplinary data and administering online student and staff surveys in the pilot schools.

MCLE and PS will coordinate a 3-day summer institute on restorative practices, along with at least two, one-day regional workshops for Maine educators.

PS will continue to increase statewide awareness, understanding and engagement with restorative practices through the publication of a semi-annual newsletter. MLCE will continue to

utilize its electronic listserv for the same purpose.

State Performance Measure 7: *The rate per 1000 of emergency department visits for asthma among women ages 15-44.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			9.5	9.3	9.1
Annual Indicator	9.9	11.6	11.4	11.4	11.4
Numerator	2648	3055	2960		
Denominator	266261	263510	259544		
Data Source					Maine Emergency Department Database
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.8	9.7	9.6	9.5	9.4

Notes - 2008
2008 emergency department data are not yet available; 2006 are used as an estimate.

Notes - 2007
2007 emergency department data are not yet available; 2006 data are used as an estimate.

Notes - 2006
Data are from Maine's 2006 hospital emergency department database.

a. Last Year's Accomplishments
Maine uses data from its statewide hospital discharge database for this measure. The most recent data available are from 2006. Emergency department visits for asthma among both men and women have not changed significantly over time in the state, but women consistently have higher rates than men. In 2006, the emergency department rate of asthma among women age 15-44 years was 11.4 per 1,000 compared to 6.0 per 1,000 men. Among females, the highest rates of emergency department visits are among those ages 15-44. Among males, the highest rates of emergency department visits for asthma are among boys, ages 0-14 years.

The Maine Asthma Program (MAP) Manager position was vacated in August 2006; filled temporarily in February 2007, with the current Manager assuming duties in November 2007. The next several months were spent re-establishing relationships with partners across the state. This work culminated in a Phoenix event on May 25, 2008 that brought together a number of former, as well as, new partners to recognize past accomplishments but more importantly to talk about ways to work together moving forward. The event ended with a re-energized group committed to addressing asthma in the state.

To address this measure, the MAP, in partnership with the Office of MaineCare Services (state Medicaid Program), developed a brochure for pregnant women; Asthma and Pregnancy (Copy included in Appendix). Any woman calling by phone to sign up for MaineCare is asked 3 questions: Are you pregnant? Do you smoke? and, Do you have asthma? If they are pregnant and have asthma the brochure is included in a package of materials that is mailed to the enrollee. 130 brochures were distributed by MaineCare and additional copies requested. Asthma

informational cards are also available on the MAP website at: http://www.maine.gov/dhhs/bohdcfh/mat/index.html under the Asthma Information tab.

The MAP also worked with the WIC program to distribute Asthma and Pregnancy brochures through the local WIC offices. 100 brochures were sent to each office. Brochures were also sent to Head Start Programs, and 25 copies were sent to each federally qualified health center.

In an effort to determine low usage rates of asthma action plans, the MAP developed and distributed a survey to 55% of Maine Osteopaths, Family Practice Physicians, Physician Assistants, Pediatricians, Nurse Practitioners, Respiratory Therapists, and all School Nurses. Analysis is underway; based on results, the MAP will convene a group of experts to develop a new action plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Healthy Maine Partnerships, to promote health and prevention of disease at the community level			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

An asthma surveillance document The Burden of Asthma in Maine: 2008 was published in FY08 (http://www.maine.gov/dhhs/bohdcfh/mat). These data reveal that the prevalence of asthma is higher among women and so is hospitalization and emergency department use. It remains unclear whether this gender disparity is due to women's inclination to seek healthcare more often than men, doctors being more likely to label women's symptoms as asthma or whether there is a physiologic difference between women and men that cause more women to have asthma and to have difficulty managing their asthma. The literature in this area is also not clear in this regard.

Several Workgroups were formed and began meeting in December 2008. The Homes Workgroup will look at how to address asthma in the home by knowing household triggers; Worksite will look at the most common triggers in the workplace and determine appropriate ways to educate employers, employer groups and workers compensation insurers on how to address the triggers to avoid lost days from work; and, the Schools Workgroup will develop a DVD for school staff on knowing the signs and symptoms of asthma, what to do about them and develop resources for school nurses.

c. Plan for the Coming Year

Pending funding from the federal CDC, Maine's Asthma Program, in collaboration with Maine's Title V Agency, plans to investigate the effects of women's asthma on childhood birth outcomes in more detail in the coming years. We will use MaineCare data to examine the prevalence of asthma among pregnant women insured through Medicaid and examine medication use associated with asthma and pregnancy.

In addition, during FY10 the MAP will collaborate with partners to carry out the following activities;
1. Disseminate educational materials to MaineCare enrollees who report pregnancy and a history of asthma,
also distribute through local WIC offices, FQHC's and Head Start Programs. Materials will reflect the new
NAEPP guidelines pertaining to asthma and pregnancy (the guidelines can be found at: http://www.nhlbi.nih.gov/guidelines/asthma/)
2. Include educational materials in mailings to all primary care providers who work with the MaineCare
population. Materials will reflect the new NAEPP guidelines pertaining to asthma and pregnancy.
3. Participate on Self Care Management Team to assist Healthy Maine Partnerships (HMP) to work with
community members who have asthma by encouraging use of the Self Care Model.
4. Participate on Worksite Team to assist HMPs develop healthy workplace programs within their communities.
Focus will be on care and treatment of people in the workforce with asthma.
5. Work with Public Health Nursing, Children with Special Health Needs, Teen and Young Adult Health, WIC,
and the Office of Minority Health to promote, inform and educate about asthma.
6. Work with HMPs in Washington County to develop a local Asthma Council, and develop an Asthma Registry
in Aroostook County hospital out patient clinics to address the high rate of emergency room visits for
asthma.
7. Work with NAACP to translate the asthma and pregnancy brochure into Spanish.
8. Work with MaineCare to disseminate a one page document that highlights the NHLBI guidelines pertaining
to asthma and pregnancy to all MaineCare physicians.

State Performance Measure 8: *The percent of licensed child care centers serving children age birth to five who have on-site health consultation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			10	11	12
Annual Indicator					
Numerator					
Denominator		720	720	720	720
Data Source					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	12	12	12

Notes - 2008
This is a developmental measure. The 2008 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

Notes - 2007
This is a developmental measure. The 2007 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

Notes - 2006
This is a developmental measure. The 2006 denominator presented is the number of licensed child care centers in Maine serving children under the age of 6.

a. Last Year's Accomplishments
There have not been any new developments in the state's efforts to develop a data system to track this performance measure accurately. Maine Childcare Facilities Licensing Rules for facilities licensed for 13 or more children require: The facility must have a written agreement with a physician, a nurse practitioner, physician's assistant, or nurse with a pediatric or childcare experience to serve as a health consultant and the facility must have a written plan approved by the health consultant. This is enforced when Maine childcare licensing staff complete their licensing reviews. In addition to having a written agreement and approved health plan, programs must provide evidence that their staff have been trained on the health plan. Childcare programs contact their health consultant to clarify specific issues and answer questions.

All Maine Head Starts are licensed childcare programs and all have health care consultants on staff. There are 86 Head Start Centers statewide.

The enhancement of a childcare health-consulting infrastructure is a primary goal in the Early Childhood Comprehensive System State Plan. The DHHS Early Care and Education Unit (ECEU) created an infant-toddler childcare professional credential that integrates social and emotional health. The ECEU and the Children's Behavioral Health Division developed and fund a system of behavioral health consultants which also sets a foundation for comprehensive health systems in childcare settings. Behavioral health consultant visits are tracked and outcomes measured. A training program for behavioral health consultants working in a childcare setting was developed and 24 consultants have been trained.

Quality for ME, a voluntary 4 step quality rating system designed to increase awareness of the basic standards of early care and education, to recognize and support providers who are providing care above and beyond those standards was implemented statewide in March 2008. The standards can be found at: http://maine.gov/dhhs/ocfs/ec/occhs/qualityforme.htm. All centers that receive subsidies are required to be in the quality rating system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Commence discussions across Maine DHHS offices to ensure coordination with the public health districts and to obtain funding support for the child health objectives of the child care health consultant network				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to National Association for the Education of Young Children (NAEYC) emerging criteria, accredited childcare centers should have a visit from a childcare health consultant twice

per year. Currently there are 72 NAEYC accredited childcare centers in Maine.

A major factor in having on-site health consultants is funding. While centers recognize the importance of having on-site health care consultant, the current economic climate has delayed the process. Funding is not available from the state to pay for childcare health consultant services and payment for services would be borne by parents who are already burdened by high childcare costs. Without payment, health professionals lack the incentive to provide on-site consultation.

c. Plan for the Coming Year

Childcare health consultants (CCHC) play a critical role in promoting healthy and safe childcare environments and supporting education for children, their families, and childcare providers. This support specifically includes children with special health needs. CCHCs also improve access to preventive health services such as medical and dental homes, early intervention and family support.

A Health Consultant will be hired with Childcare Development Funds in the summer of 2009. The consultant will attend the National Training Institute and in turn offer training to health care consultants in the state. The consultant will work with Healthy Child Care New England to coordinate and plan Health Care Consultant training.

It is a challenge to encourage consultants who must either be a physician, nurse practitioner, physician's assistant, or nurse with pediatric or childcare experience to attend training even when CEUs are awarded.

E. Health Status Indicators

Introduction

The Health Status Indicators (HSI) provide key information on several risk factors that are among the leading causes of morbidity and mortality in Maine. The data from these indicators have been used in public documents, state health plans, and direct efforts of public health programs in the state.

The Health Status Indicators reported in the Title V Block Grant inform many of Maine's priorities, including: (1) improving birth outcomes; (2) improving the safety of the MCH population; (3) improving mental health systems; (4) fostering conditions to enable the CSHN program to move to a community-based system of care; (5) improving cultural and linguistic competence; and (6) integrating services for adolescents. By continuing to track the Health Status Indicators through the Title V Block Grant, we will be able to evaluate whether we are making progress in these priority areas.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.4	6.8	6.8	6.3	6.7
Numerator	894	963	966	892	909
Denominator	13932	14111	14152	14110	13606
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: Maine Office of Data, Research and Vital Statisitics, 2008

Denominator includes all 2008 resident births.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Notes - 2006
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Narrative:
Low birth weight is one of the leading causes of infant mortality in the state. Maine's rates of low birth weight and very low birth weight have not changed substantially in the past 4-5 years and Maine has one of the lowest low birth weight rates in the U.S. However, we rely heavily on these indicators as measures of the quality and capacity of our health systems for pregnant women and children and these measures continue to be monitored on an ongoing basis. In 2008, 6.7% of infants were born weighing less than 2,500 grams. Data on this indicator were used to help pass legislation to initiate a Maternal and Infant Mortality and Resiliency Review Panel in the state. This panel will examine all infant deaths in order to examine how system change can improve care, reduce the incidence of low birth weight and premature babies, and decrease infant mortality and morbidity. A PPOR analysis was conducted and presented to the MIMR panel. Results from this analysis were consistent with PPOR analyses conducted by other states and demonstrated highest risk for infant mortality among VLBW infants.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.7	5.4	5.2	4.9	5.2
Numerator	631	743	717	671	685
Denominator	13419	13647	13703	13627	13185
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data source: Maine Office of Data, Research and Vital Statistics

Denominator includes all 2008 singleton births to Maine residents.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statistics

Denominator includes all singleton births to Maine residents.

Notes - 2006
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all singleton births to Maine residents.

Narrative:
There were 13,606 births and 13, 185 singleton births to Maine residents in 2008. Of singleton births, 5.2% were low birth weight compared to 6.7% of all births. (See HSI #01A for more information on activities aimed at reducing low birth weight in Maine.)

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.1	1.3	1.2	1.2	1.0
Numerator	148	182	176	173	134
Denominator	13932	14111	14152	14102	13606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all 2008 resident births.

Notes - 2007
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Notes - 2006
Data source: Maine Office of Data, Research and Vital Statisitics

Denominator includes all resident births.

Narrative:
In 2008, there were 134 babies in Maine that were born weighing less than 1,500 grams--1.0%. Maine's VLBW rate has been between 1.0% and 1.3% over the past 5 years. During SFY09, an

analysis of where VLBW babies were born (e.g., high risk facilities vs. other) was conducted. Results from these analyses will inform whether current transfer protocols designed to produce the best outcomes for these infants are effective. Results from these analyses will be included as part of Maine's Comprehensive Strengths and Needs Assessment for the MCH Block Grant and a report of the results will be completed by December 2009 and shared with stakeholders.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.7	1.0	0.9	0.9	0.8
Numerator	100	131	124	124	100
Denominator	13419	13647	13703	13630	13185
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data Source: Birth certificate database, Maine Office of Data, Research, and Vital Statistics

Denominator includes all 2008 Maine resident births.

Notes - 2007
Data Source: Birth certificate database, Maine Office of Data, Research, and Vital Statistics

Narrative:
Of the 13, 185 singleton infants in the state, 100 (0.8%) were born weighing less than 1,500 grams. (See HSI #02A for more information.)

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.2	6.7	7.0	7.2	7.2
Numerator	84	77	79	81	
Denominator	1174411	1149644	1126308	1126269	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 mortality data are not yet available. 2003-2007 data are used as an estimate.

Notes - 2007
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger. (Injuries).

A 5-year average is reported. The 2007 indicator is for 2003-2007.

Data are from Maine's Office of Data, Research and Vital Statistics.

Notes - 2006
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger. (Injuries).

A 5-year average is reported. The 2006 indicator is for 2002-2006.

Narrative:
HSI data on unintentional injury in Maine were used to secure funding from the Centers for Disease Control and Prevention to improve Maine's injury surveillance capacity. These data have also helped to increase collaborative efforts between Maine's Injury Prevention Program and Maine's Bureau of Highway Safety, maintain funding for a car seat safety program, and successfully tighten restrictions on teen drivers' licenses. Unintentional injury data have also been incorporated into Healthy Maine 2010, a public document that outlines the health objectives for Maine residents.

Due to small numbers, 5-year average rates are reported for this indicator. Between 2003-2007, there were 81 unintentional injury mortality deaths among children aged 14 years and younger in Maine. The majority of these deaths are due to motor vehicle crashes (See HSI #3B, #3C for more information). The Maine Injury Prevention Program (MIPP) is also involved in efforts to reduce unintentional firearm deaths, and unintentional poisonings

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.8	3.3	3.6	3.4	3.4
Numerator	45	38	40	38	
Denominator	1174411	1149644	1126308	1126269	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

2008 mortality data are not yet available. The 2003-2007 rate is used as an estimate.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2007
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. (Injuries)

Child Motor Vehical Crash Mortality is calculated as a five year average. Thus, the indicator reported for 2007 of 3.4 represents a five year average for 2003-2007.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2006
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. (Injuries)

Child Motor Vehical Crash Mortality is calculated as a five year average. Thus, the indicator reported for 2006 of 3.5 represents a five year average for 2002-2006.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Narrative:
Rates of unintentional injury and motor vehicle crash deaths among youth have not changed significantly in recent years in Maine. Between 2003-2007, there were 38 deaths due to motor vehicle crash injuries to children age 0-14, a rate of 3.4 per 100,000. However, we recognize that unintentional injuries, specifically motor vehicle crashes are one of the leading causes of death among Maine youth. Therefore, based on this data, the Maine Injury Prevention Program has identified motor vehicle crashes as a priority in their program plan and is expanding their efforts to address the issue. One of these efforts is working with Maine's Office of Substance Abuse to obtain toxicology screens on all motor vehicle related deaths in the state. With this information the program will be able to better understand the role of substance use in child and adolescent motor vehicle deaths.

The 2009 annual Maine Injury Prevention Plan was produced which includes extensive data and activities related to unintentional injury among youth. Current MIPP activities around motor vehicle crashes include:
1. An evaluation of Maine's Child Passenger Seat Program in partnership with Maine's Bureau of Highway
   Safety, and the Children's Safety Network.
2. The creation of a teen driver safety focus group including representatives from Office of Substance Abuse,
   Maine Department of Transportation, Maine Department of Motor Vehicles, AAA, Department of Public Safety,
   and the Safety and Health Council.
3. An evaluation of the Maine Safety and Health Council's Alive@25 Teen Driver Safety Program.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	26.5	27.0	28.5	27.4	27.4
Numerator	225	236	247	236	
Denominator	849929	872800	868006	862750	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 mortality data are not yet available. Data from 2003-2007 are used as an estimate.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2007
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.
A 5-year average rate is presented for years 2003-2007.

This indicator includes ICD-9 codes E810-E825. This is a slightly different definition than Healthy People 2010, which only includes E810-E819, but is consistent with prior years.

Notes - 2006
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Injuries)
A 5-year average rate is presented for years 2002-2006.

Narrative:
Motor vehicle crashes are the leading cause of death among youth in Maine age 15-24. Between 2003-2007, 236 adolescents died as the result of a motor vehicle crash, a rate of 27.4 per 10,000. In an effort to address adolescent motor vehicle deaths, the Maine Injury Prevention Program in June 2009 held a symposium on Teen Drivers, which included epidemiologic mortality, hospitalization and crash data. The goals of the symposium were to teach stakeholders more about the issue, learn about ongoing efforts in the state to improve safety among teen drivers, and identify possible interventions (See HSI #3B for more information)

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	207.4	180.8	180.0	194.9	194.9
Numerator	469	400	405	437	

Denominator	226178	221233	225055	224216	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 hospitalization data are not yet available. 2007 data were used as an estimate.

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired."

Denominator= 2007 US Census estimate as of July 1, 2007

Notes - 2007
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired."

Denominator= 2007 US Census estimate as of July 1, 2007

Notes - 2006
The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2006 among 0-14 year old Maine residents for which the principal diagnosis is an injury and the patient's disposition is not "expired."

Denominator= 2006 US Census estimate as of July 1, 2006

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2007, 437 children between the ages of 0-14 years were hospitalized for a non-fatal injury. This is a rate of 194.9 per 100,000. (See HSI #3A and #3B for activities related to reducing unintentional injuries in the state.)

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	20.3	15.4	15.1	16.5	16.5
Numerator	46	34	34	37	
Denominator	226178	221233	225055	224216	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 hospitalization data are not yet available. 2007 data were used as an estimate.

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2007

Notes - 2007
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2007 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2007

Notes - 2006
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. (Injuries)

Numerator = # of hospitalizations in 2006 among 0-14 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator= US Census estimate for 0-14 year olds in Maine as of July 1, 2006

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2007, 37 children between the ages of 0-14 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code. This is a rate of 16.5 per 100,000. (See HSI #3B for activities related to this indicator.)

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	169.1	139.6	135.7	119.9	119.9
Numerator	305	254	233	201	
Denominator	180402	182012	171682	167673	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
2008 hospitalization data are not yet available. 2007 data are used as an estimate.

Numerator = # of 2007 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2007.

Notes - 2007
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Injuries)

Numerator = # of 2007 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2007.

Notes - 2006
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. (Injuries)

Numerator = # of 2006 hospitalizations among 15-24 year old Maine residents for which the principal diagnosis is an injury, the first valid e-code is for motor vehicle traffic, and the patient's disposition is not "expired."

Denominator=US Census Bureau estimate for 15-24 year olds in Maine as of July 1, 2006.

Narrative:
Data for this indicator are from Maine's statewide hospital discharge database. These data reveal that in 2007, 201 adolescents and young adults between the ages of 15-24 years were hospitalized for a non-fatal injury with a motor vehicle traffic e-code. This is a rate of 119.9 per 100,000. (See HSI #3C for activities related to this indicator.)

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	13.1	13.6	15.1	15.3	14.8
Numerator	596	619	664	667	633
Denominator	45652	45573	43949	43500	42743
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data are from the Maine HIV/STD program.

The denominator for the 2008 estimate is based on the 2008 US Census estimate as of July 1, 2008.

Notes - 2007
Data are from the Maine HIV/STD program.

The denominator for the 2007 estimate is based on the 2007 US Census estimate as of July 1, 2007.

Notes - 2006
The denominator for the 2006 estimate is based on the 2006 US Census estimate as of July 1, 2006.

Narrative:
Maine's chlamydia rates among women has been increasing over time. This is a nationwide trend, but the reason for the increase is not clear. It may be due, in part, to increased testing efforts. Maine's STD Program is doing targeted testing with females ages 15-24 through their Infertility Prevention Project (IPP) and aims to increase re-screening of those who test positive. To address the increasing rates, the Maine STD Program is also providing treatment at the IPP sites. In addition, the program is following up testing with adequate treatment verification, case follow up for prioritized disease that includes notification of disease, and partner notification, testing and treatment. Prevention messaging and education are also provided at partner sites. Rates of Chlamydia declined slightly in 2008 among girls age 15-19, but increased slightly among women age 20-44. The increase between 2007-2008 was not as substantial as the increase between 2006-2007. Maine's HIV/STD program is continuing to conduct targeted testing and treatment and raising awareness of the importance of testing.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.1	4.6	4.6	5.4	5.7
Numerator	910	996	991	1131	1175
Denominator	220609	217937	215595	210524	206995
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data are from the Maine HIV/STD program.

The denominator is based on the 2008 US Census population estimate for women 20-44 as of July 1, 2008.

Notes - 2007

Data are from the Maine HIV/STD program.

The denominator is based on the 2007 US Census population estimate for women 20-44 as of July 1, 2007.

Notes - 2006
The denominator is based on the 2006 US Census population estimate for women 20-44 as of July 1, 2006.

Narrative:
See HIS #5A for more information on this indicator.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	14310	13353	236	134	172	6	409	0
Children 1 through 4	57149	52609	1450	524	693	31	1842	0
Children 5 through 9	72170	66915	1772	544	946	35	1958	0
Children 10 through 14	77882	73270	1457	592	959	38	1566	0
Children 15 through 19	87655	83249	1424	686	906	36	1354	0
Children 20 through 24	78383	74598	1311	707	830	26	911	0
Children 0 through 24	387549	363994	7650	3187	4506	172	8040	0

Notes - 2010

Narrative:
The health status indicator demographic data allow Maine's Title V agency to gauge the scope of the population they are charged with serving. Maine's population is becoming more diverse and the health status indicators allow Title V to track the changing demographics of the population in order to adapt our programs for a broad audience and remain aware of the need for cultural and linguistic competence in our efforts. Data for these indicators are from many programs from around the state and gathering the data has helped to build collaborations across programs.

Based on US Census estimates for Maine as of July 1, 2008, 96.4% of the population are white, 1.0% are Black/African American, 0.6% are American Indian, 0.9% are Asian, 0.04% are Native Hawaiian or other Pacific Islander, 1.1% are two or more races; and 1.3% are Hispanic. However, over time Maine's population has become more diverse, and we can see this especially among those age 0-24 years. Among those age 0-24, Whites comprise 93.9% of the population compared to 97.4% of the population in Maine over age 24; 2.0% of Maine's 0-24 year olds are Black/African American compared to 0.6% of those over age 24; 2.1% of Maine's 0-24 year old population are more than one race compared to 0.6% of the population over age 24. These

differences are even higher among the youngest children in the state. Among children age 1-4 years, 2.5% are Black and 3.2% are more than one race. A similar pattern is seen for ethnicity, as Maine's Hispanic population continues to increase. Overall, 1.3% of Maine's population is Hispanic. However, among 1-4 year old, 2.6% are Hispanic. We expect to see Maine's population continue to diversify in the coming years and many programs within the Maine CDC including the Children with Special Health Needs Program, Maine's Injury Prevention Program, Maine's Oral Health Program, and Maine's WIC program are working to improve culturally competent practices and to engage diverse communities in prevention and intervention efforts.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	14010	300	0
Children 1 through 4	55650	1499	0
Children 5 through 9	70249	1921	0
Children 10 through 14	76328	1554	0
Children 15 through 19	86198	1457	0
Children 20 through 24	77045	1338	0
Children 0 through 24	379480	8069	0

Notes - 2010

Narrative:
See HSI # 6A for more information on this indicator.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	6	5	0	0	0	0	0	1
Women 15 through 17	268	249	9	5	3	0	2	0
Women 18 through 19	849	803	19	13	7	0	6	1
Women 20 through 34	10633	10038	257	84	162	12	40	40
Women 35 or older	1847	1714	58	9	49	4	8	5
Women of all ages	13603	12809	343	111	221	16	56	47

Notes - 2010

Narrative:
Among all racial/ethnic groups, the majority of births are among those age 20-34 years. However, data on births to adolescents reveal large disparities within the state. Based on data from 2002-2006, the pregnancy rate for Whites between the ages of 15-19 was 35 per 1,000 live births. Among Black/African Americans, the rate was 59 per 1,000 live births and the rate for American Indians was 101 per 1,000 live births. The adolescent pregnancy rate among Hispanics is 42.5 per 1,000 compared to 33.8 per 1,000 among non-Hispanics. We are currently conducting in-depth analyses to examine trends in adolescent pregnancies and births by race/ethnicity and examining geographically where most of these births are occurring. In partnership with the Maine Family Planning Association, we also recently mapped all adolescent pregnancies in the state in an effort to identify gaps in services.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	6	0	0
Women 15 through 17	262	6	0
Women 18 through 19	829	19	1
Women 20 through 34	10450	168	15
Women 35 or older	1816	27	4
Women of all ages	13363	220	20

Notes - 2010

Narrative:
See HSI # 7A for more information on this indicator.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	87	81	3	0	0	0	0	3
Children 1 through 4	14	13	0	0	0	0	0	1
Children 5 through 9	12	11	1	0	0	0	0	0
Children 10 through 14	8	7	1	0	0	0	0	0
Children 15 through 19	48	46	2	0	0	0	0	0
Children 20	92	82	2	0	1	3	0	4

through 24								
Children 0 through 24	261	240	9	0	1	3	0	8

Notes - 2010

Narrative:
Due to the very small numbers of deaths among youth, it is difficult to draw any conclusions based on these data. In 2007, preliminary data suggest that there were 261 deaths among children and youth age 0-24 years. Ninety-two percent of these deaths were among Whites and 3% were among Black/African American youth. There was 1 death among the Asian population, 3 among Native Hawaiian/Other Pacific Islander and 8 with unknown race. There were no reported deaths among American Indian youth or those of more than one race, but this may be due to problems with identification of race on the death certificate. The Maine Office of Minority Health is working to improve collection of race and ethnicity data on Maine's death certificate. Maine's Maternal and Infant Mortality Panel and Maine's Child Death and Serious Injury Review Panel will continue to review infant and child deaths in the state in an effort to identify systems-level causes and possible solutions to reduce the probability of child death moving forward.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	82	0	5
Children 1 through 4	12	0	2
Children 5 through 9	11	0	1
Children 10 through 14	8	0	0
Children 15 through 19	47	0	1
Children 20 through 24	88	0	4
Children 0 through 24	248	0	13

Notes - 2010

Narrative:
See HSI # 8A for more information on this indicator.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children	309163	289396	6336	2480	3676	146	7129	0	2008

0 through 19									
Percent in household headed by single parent	32.9	32.3	0.0	50.9	0.0	0.0	0.0	44.8	2007
Percent in TANF (Grant) families	10.9	9.4	22.7	12.5	4.7	16.4	10.5	0.0	2008
Number enrolled in Medicaid	128557	107313	5150	1884	1295	147	0	12768	2008
Number enrolled in SCHIP	26296	22488	526	291	256	23	0	2712	2008
Number living in foster home care	420	120	63	21	6	0	127	83	2008
Number enrolled in food stamp program	95029	76631	3031	800	425	48	1642	12452	2008
Number enrolled in WIC	41087	36356	2171	308	443	465	1344	0	2007
Rate (per 100,000) of juvenile crime arrests	2538.0	2580.0	4838.0	1526.0	876.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.3	4.1	4.8	6.0	2.7	0.0	0.0	0.0	2007

Notes - 2010
Data are from the US Census estimates as of July 1, 2008.

Data Source: American Community Survey, 2005-2007 3-year estimates

Only data on Whites and American Indians were available. Data on specific races were not available due to small numbers, so they are included in the other/unknown category.

Counts were obtained from the Maine Bureau of Family Independence for 0-19 year olds in calendar year 2008. These numbers should be viewed as estimates--race was unknown for 11.8% of the 0-19 year old TANF clients.

The Total percent in TANF (Grant) families is an estimate based on numerator data from the Maine Bureau of Family Independence for calendar year 2008 and denominator data on children 0-19 years from the US Census Bureau for July 1, 2008.

Data Source: Office of MaineCare Services, FFY08

Race and ethnicity data are not collected separately by MaineCare. Hispanic ethnicity is collected as one of the race categories. Therefore, Hispanics are not included in the race data in indicator 9A, but are represented in 9B.

Data Source: Office of MaineCare Services, FFY08

Race and ethnicity data are not collected separately by MaineCare on SCHIP clients. Hispanic ethnicity is collected as one of the race categories. Therefore, Hispanics are not included in the race data in indicator 9A, but are represented in 9B.

Data Source: Maine Bureau of Family Independence for 0-19 year olds for calendar year 2008. Race was unknown for 13.0% of 0-19 year old food stamp clients.

Data from the Maine WIC program for calendar year 2007.

Maine's WIC program is currently undergoing a datasystem upgrade that will improve the state's ability to report accurate data in a timely manner. The system is expected to be available in Summer 2010.

Juvenile arrest rate by race includes youth under age 18. Data are from 2007. The denominator for this indicator is from the US Census estimates as of July 1, 2007 and includes those 0-17 years only. Asian and Pacific Islander race data are not collected separately, nor is there a multiple race category. Data are from the Maine Department of Public Safety's Uniform Crime Reports.

Data are from the Maine Department of Education and reflect drop-outs for the 2007-2008 academic year.

These data are a point-in-time estimate as of March 20, 2009.

Narrative:
Efforts to obtain data for the HSI forms have increased collaboration across state agencies. This increased contact is leading to improvements in Title V's surveillance capacity. For example, through contact with the Office of MaineCare Services, Maine's Title V has built the foundation for increased access to Medicaid data to link with birth certificate data. Maine's WIC program is also working closely with Title V to link birth certificates to WIC enrollment data. Further, increased involvement with the Governor's Children's Cabinet has led to significant progress in Title V's partnership with KidsCount, MaineMarks, and other data sources outside of public health.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	310613	4504	0	2008
Percent in household headed by single parent	35.2	0.0	64.8	2008
Percent in TANF (Grant) families	9.3	15.0	0.0	2008
Number enrolled in Medicaid	115789	302	12466	2008
Number enrolled in SCHIP	23584	74	2638	2008
Number living in foster home care	1806	77	46	2008
Number enrolled in food stamp program	81804	1434	11791	2008
Number enrolled in WIC	39677	1410	0	2007
Rate (per 100,000) of juvenile	0.0	0.0	2538.0	2007

crime arrests				
Percentage of high school drop-outs (grade 9 through 12)	0.0	6.1	93.9	2007

Notes - 2010
Data are from the US Census estimates as of July 1, 2008.

Data Source: American Community Survey, 2005-2007 3-year estimates

Counts were obtained from the Maine Bureau of Family Independence for 0-19 year olds in calendar year 2008. These numbers should be viewed as estimates--ethniicity was unknown for 12,1% of the 0-19 year old TANF clients.

The Total percent in TANF (Grant) families is an estimate based on numerator data from the Maine Bureau of Family Independence for calendar year 2008 and denominator data on children 0-19 years from the US Census Bureau for July 1, 2008.

Data Source: Office of MaineCare Services FFY2008

Race and ethnicity data are not collected separately by MaineCare. Hispanic ethnicity is collected as one of the race categories. Therefore, Hispanics are not included in the race data in indicator 9A, but are represented in 9B.

Data Source: Office of MaineCare Services FFY2008

Race and ethnicity data are not collected separately by MaineCare. Hispanic ethnicity is collected as one of the race categories. Therefore, Hispanics are not included in the race data in indicator 9A, but are represented in 9B.

Data Source: Maine Bureau of Family Independence for 0-19 year olds for calendar year 2008. Ethnicity was unknown for 12.4% of 0-19 year old food stamp clients.

Data from the Maine WIC program for calendar year 2007.

Maine's WIC program is currently undergoing a datasystem upgrade that will improve the state's ability to report accurate data in a timely manner. The system is expected to be available in Summer 2010.

Data Source: Maine Department of Public Safety, Uniform Crime Reports, 2007

Ethnicity not available on juvenile arrests. Data include only youth age 0-17 years.

Data are from the Maine Department of Education for the 2007-2008 academic year. Maine DOE does not collect ethnicity data separately from race data.

These data are a point-in -time estimate as of March 20, 2009.

Narrative:
See HSI # 9A for more information on this indicator.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	124594
Living in urban areas	124285
Living in rural areas	180553
Living in frontier areas	4328
Total - all children 0 through 19	309166

Notes - 2010

Narrative:
In the United States overall, about 21% of the population lives in a rural area. In Maine, 60% of the population lives in a rural area. This presents challenges for accessing health care and providing services. Maine's diverse geography and large size also makes it challenging to understand the needs of Maine residents throughout the state. However, Maine is in the process of developing a local public health infrastructure through the creation of eight public health districts. By working with the districts, which are each developing an organization structure that is community-driven, Maine's Title V program will gain a better understanding of the unique needs and strengths of the different geographies around the state.

In Fall 2007, health profiles with data for each of the districts were released to allow each district to identify areas where they may want to focus prevention and intervention efforts. Several of the Health Status Indicators, including low birth weight, motor vehicle death rate, chlamydia rates, and population demographics by race, were included in these profiles. Several of the indicators were also included in a table as part of Maine's State Health Plan. In spring-summer 2009, each of Maine's public health districts are conducting local capacity assessments to gauge how well they are able to meet the needs of their population. Results will be available in 2010.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1311559.0
Percent Below: 50% of poverty	4.0
100% of poverty	10.9
200% of poverty	27.6

Notes - 2010
Based on Current Population Survey Annual Social and Economic Supplement. Total population includes "persons in poverty universe"--all persons except unrelated persons under age 15.

Narrative:
According to 3-year estimates from the 2005-2007 Current Population Survey, Maine's poverty rate of 11.2% is the 26th highest in the United States and the highest in New England. Maine's childhood poverty rate of 14% is the second highest in New England. With the current economic climate in the state, we don't expect improvement in the state's poverty levels.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	314114.0
Percent Below: 50% of poverty	6.1
100% of poverty	14.3
200% of poverty	33.0

Notes - 2010

Narrative:
See HSI # 11 for information on this indicator.

F. Other Program Activities

Project LAUNCH

Maine submitted a successful application to DHHS, Substance Abuse and Mental Health Services Administration for "Linking Actions for Unmet Needs in Children's Health" (LAUNCH). The purpose of this project is to promote the wellness of young children, birth to 8 years of age by addressing physical, emotional, social and behavioral aspects of their development. Maine partnered with the Community Caring Collaborative in Washington County, a group of community members, agencies, providers and educational facilities that came together to create a seamless system-of-care for the County's high-risk infant population. LAUNCH is serving children ages 0-8 who have been exposed to alcohol, tobacco and/or other drugs in utero and/or those who have issues related to pre-maturity, low birth weight and other significant risks. A grant coordinator was hired in March 2009. To date an Infant and Family Support Specialist curriculum and credentialing process has been developed to increase professional expertise to be responsive to the complicated needs of infants and young children whose development may be compromised by varying factors. Other activities underway include development of a wraparound "Bridging Program" for pregnant or parenting at-risk mothers and their babies by matching trained staff with at-risk expectant mothers and their families; and integrate Infant and Family Support Specialists in rural primary health care centers with a goal of providing access to all rural health and tribal health centers in Washington County.

Maine Patient Centered Medical Home Pilot

Maine Dirigo Health Agency's Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition convened a multi-stakeholder effort to implement and evaluate a pilot of the Patient Centered Medical Home (PCMH) as the first step in achieving statewide implementation of the PCMH model. (The American Academy of Pediatrics describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.) The collaborative is working with all major private payers in the state and MaineCare to develop an alternative payment model that recognizes the infrastructure and system investments needed to deliver primary care in accordance with the PCMH model and rewards practices for demonstrating high quality and efficient care. The pilot will be evaluated using a comprehensive approach that includes nationally recognized measures of quality, efficiency, and patient-centered measures of care that reflect the six aims of quality identified by the Institute of Medicine (i.e. safe, effective, timely, efficient, equitable, and patient-centered). The ultimate goal of this effort is to sustain and revitalize primary care to both improve health outcomes for all Maine people and reduce overall healthcare costs. Four initial sites have been chosen (2 in the northern part of the state, 1 in the

central and 1 in the southern part of the state) with an anticipated start date of October 1, 2009.

WIC --New Food Package and Management Information System

The WIC food benefit package is experiencing its first major change in over 35 years. The change is significantly decreasing the amount of fat and protein and adding whole grains, fresh fruits and vegetables and baby food and infant cereals. The change goes into effect October 1, 2009 and has been a primary focus of state WIC staff activities for the past year and a half. Local agency staff, WIC participant and WIC vendor trainings will be completed during Summer 2009.

Late in FFY08, the Maine WIC Program was notified of its successful application for funding to develop a modern management information system. A project manager (Greg Schueman) was hired in January 2009. The WIC program selected the Successful Partners in Reaching Innovative Technology State Agency Model with joint application design sessions to start in August 2009. The program is also applying for American Recovery and Reinvestment Act funds to conduct an analysis and plan for an Electronic Benefit Transfer System, as well as, funds to develop the necessary external interfaces with the ImmPact 2 Immunization Registry and the Automated Client Eligibility System to allow the Office of Integrated Access and Support to determine the financial eligibility component of WIC eligibility.

Abusive Head Trauma of Infants and Young Children

The Division of Family Health (DFH) is working with the Office of Child and Family Services and multiple external stakeholders to respond to the increase in abusive head trauma (AHT) or Shaken Baby Syndrome (SBS). This work started via conference calls in December 2007 and continued monthly through FY09. The DFH Director and Early Childhood Coordinator facilitated the convening of diverse organizations and individuals wanting to address the issue of AHT/SBS. A review of the literature identified two programs for serious consideration, one developed by Mark Dias in Buffalo, NY and the Period of Purple Crying (POPC). The POPC was selected and implementation was started in March 2009. The Maine Children's Trust and Maine Children's Alliance have identified several funding sources to support various components of the program. The POPC focus is on educating parents and caregivers about infant crying and development, communicating the importance of never shaking a baby or child and that it is alright to leave a crying baby. The program is designed for families to receive the same information from multiple sources. The first time families receive information is in childbirth education classes and when they give birth. Each birthing hospital gives the family a DVD and brochure to watch in the hospital and take home with them. This allows families to share information with anyone who will be caring for their baby. Families will have a follow up conversation with a PHN or home visitor seeing them in the days/weeks after the baby's birth. Follow up conversations will also occur in the pediatric care provider offices. The Maine Children's Trust and Maine Children's Alliance are financially supporting Public Service Announcements (PSAs) so there is broad dissemination of the information to the general public. Two pediatricians, a PHN Consultant and the Perinatal Outreach Coordinator have been training hospital maternity staff, PHNs, Community Health Nurses, home visitors and pediatric providers. At least one nurse from each of the state's 30 birthing centers has been trained. Currently, 26 of the birthing hospitals are either delivering the materials to families or will be in the near future. Plans are underway to provide follow up information and education to the remaining hospitals. The AHT Prevention Workgroup is in the process of organizing materials to be disseminated to primary care provider offices by home visitors and other community partners. The PSAs will begin soon. Multiple newspapers and television stations around the state have already reported on the efforts of this issue.

Screening for Developmental Disabilities

The Developmental Disabilities Council of Maine (DDCM) is leading a pilot project to screen for developmental disabilities (DD) in primary care offices. The primary care pediatrician uses a screening tool in their office to screen for DD and autism. Through this pilot the DDCM hopes to

develop a system of care for screening and evaluation to improve outcomes for children. Initial challenges for this effort are lack of third party payment for screening and care management as well as availability of service resulting from a shortage of speech therapists trained in this area for very young children. The MCH Medical Director and CSHN Director are working with the DDCM on designing and implementing this initiative.

PHN Accreditation

Maine Public Health Nursing Program (PHN) has entered into the process of voluntary national accreditation. A self study was submitted to the Community Health Accreditation Program (CHAP) in April, 2009 after a year and a half of preparation. This self study encompassed an assessment process in four areas: structure and function, quality of services and products, human, financial and physical resources, and long-term viability, in both the Core and Public Health standards of excellence.
The PHN program objectives for seeking accreditation were to:

- Increase PHN's ability to respond beyond emergent PH issues
- Focus on strategic organizational issues
- Improve standards of nursing statewide
- Be better prepared for resource allocation in a dynamic environment, and
- Be equipped with an effective change process to improve PHN response to ever changing public health demands

CHAP site visits will occur in fall 2009.

G. Technical Assistance

Please refer to Form #15. We will request technical assistance from the Maternal and Child Health Bureau and other appropriate entities such as other State Public Health Agencies, Academic Institutions with expertise in public health and public administration, non-profit organizations with MCH/CSHN expertise, and other federal partners such as the Centers for Disease Control and Prevention for the following:

1. Technical assistance on implementing strengths based assessment.
2. Technical assistance for cultural and linguistic competence within Title V programs.
3. Technical assistance with survey analysis.

The above requests for technical assistance are in order of priority. Technical assistance #1 was selected in preparation for the 2010 CSNA. During the development of the 2005 CSNA, understanding of the general concept of strengths based assessment was developed; however many questions remained regarding how does one really conduct an assessment of strengths. The literature has grown in the area of assessing individual strengths, but it was very difficult to locate literature and guidance regarding assessment of the strength of systems. From an epidemiologic perspective questions remain on how to integrate data from multiple sources; how to choose a model; how to put the concept of a strengths based assessment into practice/action. Maine specifically is asking for assistance in defining measures of system strength and the preparation of a plan for system assessment. Technical assistance in this area will assist the state of Maine in conducting the 2010 Comprehensive Strengths and Needs Assessment and integrating this information into our programs. Based on responses to the Region I workshop on including strengths in the 2005 Comprehensive Needs Assessment, it appears that interest in this topic is shared widely among Title V programs in the US. Our New England Region I State Title V Programs have taken this on as a regional priority.

The request for technical assistance #2 was selected for continued progress in the development of culturally and linguistically competent systems of care for the MCH population in Maine. Such progress is an essential component for creating and sustaining humane policies and services.

This is particularly important as the population in Maine becomes more racially and ethnically diverse, and as we become increasingly aware of the impact of class and geography on health disparities. Specifically, Maine is asking for assistance in identifying tools to assist our many partners in their endeavors to be culturally and linguistically competent for all persons living in Maine.

The request for technical assistance (#3) for survey sample analyses was selected because the Maine Title V program uses several surveys to address the needs of the MCH population including PRAMS, the Youth Risk Behavior Survey, the Behavioral Risk Factor Surveillance System and the Maine Child Health Survey. Survey data require analytic techniques that are not familiar to all staff and there have been changes to statistical software, specifically SAS, to conduct these analyses. The Maine CDC MCH epidemiologists and program staff could benefit from a training on survey analysis that would include topics such as: combining years of weighted data, using SAS to analyze survey data, and conducting regional analyses of stratified data. We have identified an expert in survey sampling analysis, Donna Brogan, who provides trainings in these topics. Assistance in the area can be accomplished by procuring/arranging a training session in Maine.

V. Budget Narrative

A. Expenditures

For a summary of any variances please refer to Section VB - Budget.

B. Budget

The Division of Family Health expended $19,485,747 for maternal and child health services in FY08; including $15,978,630, of state funds and $3,507,118 of Title V funds. Expenditures by populations served include 58% ($11,240,455) expended on primary care and preventive services for children; 18% ($3,432,780) expended for children with special health needs; 5% ($879,170) expended for pregnant women; 18% ($3,598,645) for others; and just under 2% ($334,697) for administration. The other category is comprised primarily of women of reproductive age who are not pregnant or recently postpartum. In FY 08 there was a slight increase in expenditures by all population groups.

Delineating expenditures by levels of the MCH Core Services Pyramid, 56% ($10,909,142) was expended on direct services; 6% ($1,120,253) on enabling services; 12% ($2,314,837) on population based services; and 26% ($5,051,515) was expended on infrastructure building services. The slight decrease in direct and enabling service level expenditures supported a slight increase in expenditures for population-based and infrastructure services. Overall expenditures in FY08 were $1,140,885 more than budgeted. This is a result of carryover of SFY07 state funds being carried forward.

In FY10 the Division proposes to spend $3,507,117 of Title V funds, with no carry forward from FY09. Of the Title V funds, 63% ($2,209,491) is allocated to primary care and preventive services for children; 30% ($1,055,484) to children with special health needs; and 6.9% ($242,142) is available for administrative expenses. Considering the total federal and state budgets, the Division proposes the following expenditures, categorized by level of the MCH Core Services pyramid: 56% ($7,334,758) will be allocated for direct services; 6% ($813,713) for enabling services; 12% ($1,556,380) for population based services; and 26% ($3,396,384) for infrastructure building services.

The FY10 budget is $837,619 less than FY09. The FY10 budget passed by the Legislature and signed by the Governor includes a reduction of $837,619 in State MCH funds. The reductions occurred in oral health, home visiting, MCH nursing, and small amounts in CSHN, Newborn Bloodspot Screening and general administrative expenses. Included in the annual MCHBG budget is approximately $70,000 to cover expenses related to out of state travel to attend regional or national meetings that are important in advancing the health of Maine's MCH population. These funds will be used by staff in the programs working with the MCH population on the priorities outlined in the comprehensive strengths and needs assessment.

Regional and national meetings staff will attend during FY10 include: MCHB Partnership, Association of Maternal Child Health Programs (AMCHP), American Public Health Association, National Association of School Based Health Centers, National Network of State Adolescent Health Coordinators, Association of State and Territorial Dental Directors, Society for Adolescent Medicine, Association of State and Territorial Directors of Nursing, New England Regional Genetics Group, National Eating Disorders, National Newborn Screening and Genetic Testing Symposium, National Women's Health Coordinators, State and Territorial Injury Program Directors Association, American Cleft Palate Association, National Birth Defects Programs, National Perinatal Association, Newborn Bloodspot Screening Program, North American Brain Injury Society, American Evaluation Association, Region I MCH and CSHN Directors Regional meetings, North East Regional Public Health Leadership Institute, on-site Public Health Prevention Specialist interviews at Federal CDC, Women's Health Summit, March of Dimes Annual Meeting on Quality Improvement to Prevent Prematurity, Annual New England Birth

Defects Consortium, as well as, Region I Women's Health Workgroup quarterly meetings. Maine will send the Title V Director, CSHN Director, and MCH Medical Director to the annual AMCHP meeting and annual MCHB Partnership meetings. Conferences include: MCH Epidemiology, American Association of Suicidology, MCH Leadership Institute, Leadership Enhancement in Adolescent Health, Life Savers, Moving Kids Safely, Region 1 Minority Health, Public Health Nursing Informatics, and conferences or meetings that are needed as a part of the orientation of new staff and for staff development. In addition Nancy Berkhimer will attend 2 to 3 meetings to share Maine's innovative and collaborative approach to student health survey data collection, the Maine Integrated Youth Health Survey (MIYHS). The federal CDC assigned Public Health Prevention Specialist will attend two multi-day national conferences relevant to the assignee's scope of work with Maine CDC.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.